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ABSTRACT

This study reviews and analyzes family planning legislation in seven countries of the Mediterranean region: Greece, Italy, Morocco, Portugal, Spain, Tunisia, and Turkey. Part 1, a general review, specifically focuses on the role of religion in the development of family planning programs, laws with an indirect effect on family planning (minumum age of marriage, polygamy, divorce, incentives and disincentives), laws with a direct effect on family planning (contraception, voluntary sterilization, induced abortion), and teenagers and family planning (family planning services, voluntary sterilization, induced abortion, sex education). Part 2 contains country profiles of the seven countries involved in the study. Recommendations specific to the country conclude each profile. Part 3 offers conclusions and recommendations regarding legislation with an indirect effect on family planning, legislation with a direct effect on family planning, family planning for adolescents, and conferences. Appendices include a bibliography, a summary of laws affecting family planning, and population facts. (YLB)

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Family planning legislation

Report on a survey

by

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INTRODUCTION

Throughout the world, family planning is acknowledged to be an issue of critical importance, yet there has been little analysis of the legislation existing in this area. The present study, initiated by the WHO Regional Office for Europe, attempts to help fill this gap by reviewing and analysing family planning legislation in seven countries of the Mediterranean region: Greece, Italy, Morocco, Portugal, Spain, Tunisia and Turkey.

Those involved in the field of family planning have recently begun to recognize the role that law can play either in implementing family planning programmes or in impeding their development. As the International Planned Parenthood Federation pointed out: "The importance of law to family planning programmes ought not to be underestimated by anyone. To borrow from the realms of journalism, law as it relates to family planning may determine who can 'do' what to whom, where, how, when and for what reasons, and hence may exert a controlling influence on family planning programmes."

The law is often viewed as a conservator of the existing system and as such it can inhibit family planning programmes. But the law can also assist in making positive inroads in this area. Within the past ten years, all the countries in this study have made significant changes in their laws which have aided the development and expansion of family planning programmes. Among the changes that some of the countries have introduced are: permitting the distribution, importation, manufacture and advertising of all types of contraceptive; introducing maternity benefits and time off for breastfeeding; integrating family planning services into existing health services, usually maternal and child health services; and removing procedures for sterilization and abortion from criminal law and treating them as medical issues.

In attempting to examine and evaluate family planning law, it is important to consider both the law in theory and the practice generally followed in a country. Sometimes there is a wide divergence

between them. For example, Greece has a strict law prohibiting abortion, yet the law is widely ignored. The number of illegal abortions performed yearly has reached epidemic proportions. In this instance, there appears to be such wide consensus about the practice that the law is rarely enforced.

At times, laws that have become outdated remain on the books long after they have stopped being applied. Laws that might have been appropriate during the period of colonialism, such as those pertaining to a pronatalist policy, may no longer be apt today. Yet because law reform is not always a priority in new and independent nations, many of these outmoded laws remain on the books. This often results in the laws being ignored while new programmes designed to handle the problems are developed and implemented. There may be a long time-lag until the laws on the books are brought into line with the practice in the country.

Besides the gap between theory and practice, laws may be translated into practice more narrowly than they were drafted. Laws are open to interpretation, and policy-makers may feel safer from criticism if they choose the most conservative meaning.

Lay people often look only to legislation and statutes when defining the law. This perspective is too narrow. In this survey, "law" includes legislation, administrative regulations, executive orders, judicial decisions, medical codes of ethics (often enacted as statutes or issued as regulations) and religious and customary law.

Finally, it is important to note that even where laws are designed to help encourage family planning measures, none of the countries studied has mandatory population control. Rather the laws have been developed to improve family health, to help implement the country's economic and social policies, and/or to encourage people to have more control over their own lives by choosing how many children to have, and when.

On the other hand, the cultural, economic and religious influences of a society may set a high premium on having a large family. There are many obstacles to any law that might be proposed to regulate high fertility. In many rural areas children are an important economic asset: they work in the fields and supplement the family's earnings. Some of the societies in the Mediterranean region still distribute land according to how many sons a family has, and the larger the family the more likely it is that it will contain more boys. In addition, none of the countries surveyed has the financial resources to provide adequately for its elderly. Children therefore constitute a necessary investment for the future. They can help guarantee their parents' financial survival in their later years. Finally, many religious leaders strongly oppose any type of contraception, as well as sterilization and

abortion, and their views are rigidly adhered to by many of their followers.

At its best, the law is only one of the factors that can influence population growth. To be effective laws must be coupled with education, socioeconomic development and attitudinal change.

Although altering the law is not sufficient to create major changes in family planning, it is clear that it is an important factor. A first step towards introducing legal reform is to develop a knowledge of the existing laws.

The present study, by analysing those laws in the Mediterranean region that have a bearing on family planning, is designed to show how the law can impede or aid family planning programmes. This type of analysis may serve as a starting point for a country to modify its current legislation or to introduce new initiatives. The laws are analysed according to whether they have a direct or indirect impact on family planning. The former include those regulating sterilization, abortion and contraception. Laws that indirectly affect family planning include those regulating the status of women at home and in society (such as marriage and divorce laws, and laws relating to maternity leave and benefits and nurseries) and social security and labour laws.

An analysis of these laws raises the question of which laws are most important if a society wishes to control population growth.

Survey of existing literature

At present, there is little information about the legislation that exists in the area of family planning in the countries of the Mediterranean. An outstanding, though non-comprehensive study, *Law and planned parenthood*, has been produced by IPPF (*1*). Although it discusses most of the relevant topics, it does not include data or material for many of the Mediterranean countries.

The United Nations publishes several useful surveys. The *Annual review of population law* produced by the United Nations Fund for Population Activities (UNFPA) is designed to provide both specific and general information on recent worldwide highlights and trends related to various aspects of population law. It is published yearly but the most recent volume does not contain much information on the countries in the Mediterranean. The UNFPA (*2, 3*) has also published a comprehensive survey of contraceptive laws and a survey of laws on fertility control. Although these surveys are extremely helpful, some of the information is already out of date. In addition, since the surveys depended entirely on written correspondence between UNFPA and individual countries, some information was unobtainable, for

example the age requirements for voluntary sterilization in Portugal.

The Population Council has also published some excellent literature in this field. One of the most comprehensive works on abortion is Christopher Tietze's *Induced abortion* (*4*), a Population Council Fact Book. This book, however, discusses abortion laws only. The World Health Organization (WHO) (*5*) has also published some literature on abortion laws including *Abortion laws in Commonwealth countries*. As its title indicates, this book deals exclusively with the Commonwealth.

Population reports, a bi-monthly journal published by Johns Hopkins University, is designed to provide an overview of important developments in the population field. For example, the March–April '981 issue contains the most up-to-date information on legal trends in voluntary sterilization.

The *International digest of health legislation*, a quarterly journal published by WHO in Geneva, includes a selection of health law texts, studies in comparative health legislation and a bibliography.

The present study was undertaken to provide complete information about family planning legislation in an important region of the world that has not been focused upon in previous surveys in this field.

How the study was made

Most of the material for this study was gathered by the author during on-site visits in June–July 1981. Each visit lasted three days. The ministries responsible for health in each country were contacted prior to the visit and asked to cooperate by setting up a programme for the author. Although the issues to be covered were explained in the initial letter, it was left to the discretion of the authorities in each country to select the appropriate individuals they wished the author to meet. Consequently there was no uniformity in the type of people met: they included staff of the ministry responsible for health, lawyers connected with the health ministry or with university departments of forensic medicine, demographers, doctors, nurses, midwives, paramedical workers and representatives from nongovernmental family planning agencies and women's organizations. The author also visited at least one family planning centre in each country.

PART I

GENERAL REVIEW

FAMILY LAW: RELIGIOUS BACKGROUND

In each of the seven countries surveyed, religion plays an important role in the development of family planning programmes.

The Roman Catholic Church

The primary religion in Italy, Portugal and Spain is Roman Catholicism. Historically, the Catholic Church has opposed all forms of artificial contraception, as well as induced abortion and voluntary sterilization, except where the life of the mother is severely endangered. Natural methods of birth control and abstinence have been the only officially sanctioned methods of fertility regulation. Procreation is encouraged.

The Greek Orthodox Church

In Greece, where family planning is just in its infancy, the Greek Orthodox Church is the official Church. The Church prohibits, condemns and punishes not only abortion but also the avoidance of procreation. According to the Rule of the Elvira's Synod, a woman who induces abortion is punished by not being permitted to receive holy communion until the last moments before her death.

The Greek Orthodox Church believes that every human being including the fetus is entitled to life. Only in very exceptional cases, where the life of the mother is in danger, can the physician make the decision to abort the fetus. The Church prohibits the use of any drugs that cause abortion as well as any means of controlling conception. A married woman who takes measures to prevent conception is barred for three years from receiving holy communion, according to the 21st Rule of Fasting John (*6*). Abstinence and the "rhythm method" are accepted.

In recent years, there has been so much publicity about the large number of illegal abortions in Greece that the Church has created a

special committee to review the problem. An encyclical was distributed among priests stating the Church's position on abortion (6). The encyclical stated that "the murderous trend of inducing abortion is threatening the nucleus of the family unit and endangering the survival of our nation". It urged believers against "this destructive trend" and asked them to "realize that children in a family are a blessing not a curse".

Islam

Morocco, Tunisia and Turkey are Muslim countries. For many Islamic nations, law and religion have historically been inseparable. The Islamic religion has always supported the proliferation of the faithful and a belief that Allah will provide for everyone. In the past this has led to a policy of population growth. In formulating Islamic law, known as Sharia (the straight path), legislators first look to the Koran and then to the teachings of the Prophet. Sharia is the expression of Islamic thought and of the Islamic way of life. In the past, it regulated every part of Muslim life, and it is still the basis of much of the legislation in Morocco and Tunisia. In these two countries, the law is often divided into two categories: that which affects personal status and is based on the teachings of Islam, and that which deals with administrative matters and is based on modern European law. Even though civil law is enforced, religious law is widely respected and consulted.

Although the majority of Turkey's population is Muslim it is a secular country, and there is a tradition dating from independence in 1926 of separating religious and state affairs.

In Morocco and Tunisia, before independence from the French in 1956, the religious tribunals and judges applied a family code based on an interpretation of the Koran and the Sunna (the teachings of the Prophet).

The attitudes towards family law have differed widely in the two countries since independence. A partial explanation for these dissimilarities may be the necessity in Morocco to integrate many ethnic, geographical and tribal differences into a unified legal system. This resulted in a political "compromise" – the Family Code of 1956. These differences do not exist in Tunisia. The leadership in the two countries has also had different orientations. While Tunisia has moved towards modernization and progressive reforms, Morocco has been anxious to maintain traditional values and a more conservative way of life.

One reflection of the differences between the two countries may be found in the laws on polygamy. Tunisia prohibited the practice in

1956. Morocco has maintained this practice as it existed before independence, although only a small percentage of the male population actually marry more than one wife.

Unlike the two religions previously discussed, Islamic teaching does not forbid the use of contraceptives. An international conference on Islam and planned parenthood (*7*) was held in Rabat in December, 1971 and was attended by religious scholars from 24 Islamic countries. They reached the conclusion that Islam permitted the use of contraception:

> That the Islamic Law, through its provisions, whether recorded in the Koran or the traditions or inferred from other recorded provisions according to the methods of inference and *ijtihad*, ensures that the Muslim family will be able to tackle successfully any new situation and have it under control, with correct and sound solutions and measures.
>
> That the Islamic Law allows the Muslim family to be able to look after itself as regards the procreation of children, whether this is in the sense of having many or few of them. It also gives it the right to deal with sterility and to arrange suitably spaced out pregnancies and to have recourse, when needed, to safe and lawful medical means.

In the case of abortion, Muslim jurists differ. Some have expressed the view that the fetus has an undeniable right to live, but the opinion of the Muslim theologians (*7*) at the Rabat Conference was:

> Upon the subject of abortion, i.e. the expulsion of the baby-to-be from the uterus with the intention of disposing of it, the Conference is of the opinion that all Muslim scholars in jurisprudence are agreed that it is forbidden after the fourth month, except for extreme personal necessity for saving the mother's life. For the period before the end of the fourth month, although there are numerous different opinions among the scholars in jurisprudence, the correct view tends to forbid it at any stage unless for extreme personal necessity to save the mother's life, or in the case of there being no hope for the life of the foetus.

In Tunisia abortion has been effectively legalized for all women until the end of the third month (Section 214 of the Penal Code, as amended by Law No. 65-24 of 1 July 1965). Morocco, on the other hand, has legislation that makes abortion in most circumstances a punishable crime (*8*) (Articles 449–458 of the Penal Code, as amended by Crown Decree No. 181-66 of 1 July 1967).

LAWS WITH AN INDIRECT EFFECT ON FAMILY PLANNING

Laws relating to contraception, sterilization and abortion have a direct impact on fertility regulation. There are also many other laws that indirectly affect family planning: age at marriage, polygamy, child allowances, maternity benefits, social security and labour laws. They relate to the legal status of women in the family and in society. Although custom and tradition are important factors in determining how women are viewed and treated in any country, the law helps to define woman's actual position. These laws may play a more significant role in fertility regulation than is generally recognized.

Minimum age of marriage

Over the past decade, most of the countries in the survey have reformed their marriage laws by either raising or establishing a minimum age of marriage. Theoretically, by introducing or increasing a minimum age, especially in countries where there is a low rate of illegitimacy, fertility can be influenced since the number of childbearing years within marriage is decreased. Yet several countries surveyed expressed concern that there continues to be a persistent disregard of the law.

In some instances, families with daughters below the legal marriage age arrange religious and not legal marriage ceremonies for them. When these couples reach the legal age, they may also have a legal ceremony. Since many people do not have copies of birth certificates, there is no way of ascertaining their exact age. Furthermore, judges often have the discretion to waive the minimum age requirement. This is usually contingent on the couple meeting certain prerequisites such as obtaining the consent of parents or guardians or the bride being pregnant, but there are few known instances where these requests have been denied.

It seems evident that this law will not be effective unless it is combined with other measures outside the legal sphere. If girls are not offered other options, including job or educational opportunities, they will have little incentive to postpone marriage.

Catholic countries

Italy. In 1975, Italy reformed its family law to create more equality between men and women. Prior to that time, the age of marriage differed: for men it was 16 and for women 14 years. Now both men and women must be 18, which is also the age of majority (Law No. 151 of 19 May 1975). With the permission of the court, minors can

marry from the age of 16, but the couple is required to use a consultation service that determines whether they are of "sufficient maturity". According to Dr Paolo Benciolini, Professor of Forensic Medicine at the University of Padua, the courts are very lenient and about 80 % of such couples receive permission to marry. Although in earlier times girls of 12 were allowed to marry, 16 is now the minimum age for this permission to be granted.

Sixteen is also the minimum age for people to be considered parents "by right". If they are below that age, the court may give the child to the grandparents or put it up for adoption.

Portugal. Since the Revolution in 1974, Portugal's family laws have become the most progressive of any of the countries surveyed. A new law (Decree-Law No. 496/77) that became effective on 1 April 1978 introduced profound changes into the Portuguese Civil Code. Among other points, wives were given full equality with their husbands.

In Portugal the minimum age for marriage is 16 for both men and women; under no circumstances is it permissible to marry before that time. Men and women need parental consent until they reach 18, the age of majority. All marriages must be publicly registered.

Marriage is based on the concept that men and women have the same rights and duties. Family affairs are managed by both partners, and both must contribute towards the family's upkeep in accordance with their means. The law does not distinguish between the tasks to be carried out by either partner and puts domestic work on the same level as professional work.

Normally, acquired property is considered to belong to both parties, although they are free to develop any system of property sharing they desire. The disposal of any property requires the agreement of both the husband and the wife.

Spain. Under the Civil Code, Paragraph 46, a person may not enter marriage if she or he is an unemancipated minor or already married. The age of majority is 18 years for both sexes. According to Paragraph 48, however, a judge has the right to waive the requirement of majority, after having heard the minors and their parents/guardians, thus making a legal marriage possible if the spouses are 14 years or older.

Muslim countries

During a symposium on law and population in the Middle East and North Africa in 1976 (*9*), it was stated that under Islamic law (*Sharia*) marriage is lawful at the age of puberty for both sexes, puberty being

a physical state attained when the boy experiences wet dreams and the girl menstruation. This age could begin as early as 12 for boys and 9 for girls. Puberty as such is considered to end at around 15 for both sexes. In all the Muslim countries in the survey, however, the minimum age of marriage is later than puberty.

Morocco. Prior to the promulgation of the Family Code in 1956, classical law was applied. Under the old law, the age of marriage was set at puberty. but the father had the right to marry his children without their consent (*Jabr*) even before the age of puberty. Although *Jabr* generally no longer applied to the boy when he reached puberty, it continued to apply to the girl unless she was declared emancipated or until a first marriage was dissolved.

Islam permitted the girl to dispute the right of the father to marry her against her will, but in practice women rarely fought this condition. This was one of the reasons that led to some social reform in this area, the abolition of *Jabr* and the introduction of an official minimum age of marriage.

The new Family Code introduced the age of marriage as 15 for women and 18 for men. Compared to other countries in the region this is a relatively low age of marriage, particularly for women, but it represents some progress when compared to the Islamic tradition.

Although the law specifies a minimum age, it allows some deviation. Regarding the age for men, if great difficulties are to be feared, the judge may authorize an early marriage. This possibility can also be used for girls who reach puberty before the age of 15. Furthermore, the law authorizes the judge to marry the girl without her consent if the family fears the girl may engage in premarital sexual relations (*9*).

In writing a law dealing with the age of marriage and the age of consent, the legislature was mainly concerned with maintaining the more traditional customs of the country.

Tunisia. The Code of Personal Status has regulated marriage and divorce since 1956. Prior to that time, the Muslim Code dealt with family law. Today, the minimum legal age is 20 for men, and 17 for women with parental consent or 20 without, according to Law No. 164 of 20 February 1964. To avoid earlier illegal marriages, all marriages must be registered in the municipality. The consent of both parties is also required.

Turkey. The age of marriage was established by the Turkish Civil Code in 1926. At that time the age was set at 18 for men and 17 for women. An amendment was introduced in 1938 lowering the age to 17 and 15 respectively. The main purpose of the law was not to

encourage fertility but to acknowledge the rural customs that recognized common law marriages at that time. This was done in an attempt to integrate the rural population into the new state.

With the permission of a judge, the age can still be lowered to 15 and 14 respectively, though there are many marriages with religious ceremonies below that age.

Under the Turkish Penal Code, it is a crime punishable by imprisonment of 2–6 months to marry in a religious ceremony without also having a civil ceremony. Nevertheless, few people are prosecuted under this law as it is extremely difficult for prosecutors to prove that people are married and not just living together.

Recently, the Minister of Health and Social Assistance requested the Justice Minister to raise the age of marriage from 15 to 18 for women and from 17 to 20 for men. The Justice Minister refused the request on the grounds that there were still too many illegitimate births and a higher age of marriage would only increase this rate of illegitimacy.

In practice, there continues to be early marriage in rural areas of girls between 12 and 15. This frequently happens without the girls' consent and they are forced to marry in illegal religious ceremonies.

These marriages continue to flourish despite a series of legal decisions in Turkey prohibiting the practice. Besides the Civil Code, which sets a minimum age of marriage, Turkey has ratified the United Nations accord on the abolishment of slavery, slave trade and slavery-like institutions and practices. This code prohibits the marriage of women without their consent. There was also a court decision in 1976 that condemned any form of restriction on individual freedom in the acceptance of a marriage contract, and held that brideprice payments to fathers in exchange for their daughters were unlawful and against human rights.

The difficulty, however, is in enforcing these documents. Women who are forced to marry against their wishes often run away and place themselves under police protection. Generally, they are merely returned to their fathers, who are rarely prosecuted for violating their rights.

Greece

Unlike most of the other countries in the region, Greece is suffering from a declining birth rate. The minimum age of marriage is 15 for women and 17 for men. Parental consent is not required since the age of majority is 15.

Despite the legal minimum age, few people marry at those ages. The average age at marriage is 22½ years for women and 28 for men.

One explanation is that Greece has a high rate of emigration, especially among young men of marriageable age. They often leave the country for several years, go to one of the northern European countries as "guest workers", and return after they have earned some money. It is only after their return that most take a wife.

Conclusion

At present, it is clear that not all of the countries surveyed require that both partners consent freely to a marriage. There are few regulations regarding the registration of marriages and births. Only Italy and Portugal have the same age requirements for men and women, and most countries have many loopholes, either legal or customary, whereby people may marry below the minimum age.

Polygamy

Only the Muslim countries have ever permitted polygamy. The Koran (Verse 3, *Sura.* 4) permits polygamy (*7*): "Take in marriage of such other women as please you, two, three or four. But if ye fear that ye cannot act equitably towards so many, marry only one. This will be easier, that you swerve not from righteousness."

Muslim countries

Morocco. According to Dr Mohamed Bouzidi (*9*) formerly a professor of law at Rabat University and currently Regional Director of IPPF, the practice of polygamy in Morocco was limited to the upper classes, prior to the writing of the Family Code in 1956. In rural areas, tribal chiefs also used it to consolidate their position by marrying into other tribes. Thus the practice was used as a means of population growth. In urban areas it was fashionable among the upper echelons of the traditional bourgeoisie, who often married a servant after a pregnancy. Recently, polygamy has almost disappeared in the upper classes but is still practised among rich landowners who have moved from rural to urban areas. In 1963, a survey (*9*) showed that 3.1% of married men in rural areas had more than one wife, while a 1974 estimate put the figure at 3%. It is felt that these figures are conservative.

Unlike some of the other Muslim countries, however, Morocco has introduced certain legal restraints on the practice of polygamy. Article 31 of the Moroccan Code of Personal Status gives the wife the right to insert a statement into the marriage contract forbidding the husband to marry a second wife. If he violates the agreement, she has

the right to terminate the marriage. The second wife is also required to be informed of the previous marriage.

Dr Bouzidi (9) indicates that these limitations remain theoretical. Marriage officials say it is rare for these conditions to be included in the contract. He asserts that polygamy is one reason for the increasing population growth. In 1975 the National Union of Moroccan Women recommended the abolition of this practice.

Tunisia. Polygamy was abolished in the sweeping reforms that took place after independence in 1956. Article 15 of the Tunisian Code of Personal Status states that polygamy is prohibited. Anyone who is party to a marriage, and contracts another marriage before the dissolution of the first, is liable to be sentenced to one year's imprisonment and/or a fine of 240 000 francs, even if the new marriage was not contracted in accordance with the law. The legislation is strictly enforced in Tunisian courts.

Turkey. Polygamy is illegal but is practised in a limited way in rural areas and in the slums around Ankara.

Divorce

It is difficult to prove exactly what effect divorce has on family planning. It seems likely, however, that in countries where divorce and remarriage are easier, the fertility rate is increased. This is probably particularly true where older men remarry younger women and begin second families.

In general the laws on divorce do not treat the couple equally, it being frequently easier for the man to obtain a divorce and to maintain control over the property. Even in countries where the laws do not discriminate, the stigma attached to divorce may be far greater for the woman. In those countries women, particularly those without skills or training, may find that liberalized laws do not make their social reality any easier.

If women are going to be able to choose freely whether or not to remain in a marriage, the laws and customs of society that give them equal job and educational opportunities and training will be as important as laws that make divorce easier to obtain.

Catholic countries

Italy. Before 1970 Italian law did not permit divorce. In 1970, Law No. 898 was passed permitting divorce after a separation of five years. A 1974 referendum confirmed this Law. In the first years after its enactment, the Law was frequently used.

Portugal. Divorce was not recognized before 1975. Under the present law, Decree Law No. 261 of 1975, husbands and wives enjoy the same status. Either can obtain a divorce on the grounds of separation for six or more years or on the basis of the guilt of the other party (e.g. adultery).

Spain. Divorce not being recognized by the Catholic Church, valid and consummated marriages could not legally be ended by divorce until 1981. In that year a new law that allows divorce by mutual consent reintroduced divorce more than 40 years after it was abolished by the former regime.

Muslim countries

Morocco. Much of the divorce law is still governed by Islamic law. One of the ways marriages can be dissolved under Islamic law is by repudiation. This is a unilateral termination of the marriage by the husband. He simply renounces the marriage three times either in writing or orally. After the renunciation, he must inform the Sharia court of his decision. Under this type of marital dissolution, the repudiated wife is entitled to a consolation gift, the amount of which is determined by her circumstances. Repudiation is not permissible during the wife's menstrual period (*9*).

Morocco also recognizes judicial divorce in cases of mutual consent. A wife can divorce her husband in exceptional circumstances such as his prolonged absence or for certain vices, but divorces in Morocco are rarely demanded by women.

Tunisia. In 1956, one of the reforms that Tunisia introduced in the Code of Personal Status was the abolition of repudiation. In 1981 a new divorce law was instituted in the country, modifying the Code of Personal Status. Under the new law there are three grounds for divorce: 1. mutual consent; 2. one of the spouses may ask for divorce because of some fault or action of the other spouse; 3. one or the other spouse may ask for the divorce without the spouse being at fault. If the wife has suffered a material prejudice, she is entitled to alimony so that she can continue to live in the style she was accustomed to during her marriage.

Turkey. Under the Turkish Civil Code there is equality of the sexes. The law makes no distinction between men and women and both can apply for divorce. Seventy-five per cent of divorces are granted on the grounds of incompatibility, 10% for adultery, 10% for desertion and 5% for various other reasons.

The husband nevertheless has superior rights in the marriage

contract, while the woman has the duty to obey and help. The husband is also the head of the marriage and has the final choice in place of residence.

Women who commit adultery are subject to imprisonment while a man is punished only if adultery takes place within his wife's residence or in a place where it becomes public knowledge, or if he lives permanently with another woman.

Greece

The Greek Civil Code, Sections 1438–1462, sets out the grounds for divorce. Men and women are treated equally under this law. Divorce must be granted if one of the partners commits adultery or bigamy, is legally declared dead, has leprosy or has been declared insane for four years. The judge also has the discretion to grant a divorce on the grounds of mutual mental cruelty. Before the divorce is granted, the couple must receive counselling from the church. If the "guilty party" refuses to go for the counselling within three months, however, the person bringing the action can go directly to court.

Although the law considers men and women equal, in practice it is often difficult for women to decide to seek a divorce, mainly because of the financial considerations.

Incentives and disincentives

Laws that improve working conditions for women could serve as an incentive to bring them into the labour market in greater numbers. This in turn could change the habitual role of women as wives and mothers and give them more economic and educational opportunities in the traditionally male dominated society. These options might have a marked impact on the number of children women choose to have.

In order for these employment opportunities to be realistically available to women, especially in countries with a high rate of unemployment among men or a cheap supply of labour, new job opportunities must be created to absorb the existing workforce. Unless these measures are taken, there will be little incentive for employers, public or private, to try and attract women into the labour force.

There are various types of incentive and disincentive that are indirectly related to family planning.

Family allowances

Family allowances, given for any number of children, might be viewed as an incentive to have more children. Most of these

allowances were introduced during pronatalist periods in a country's history and have remained as laws long after the official policy on family planning has changed. In most of the countries, the amount given nowadays is so small that it covers only a slight proportion of the expense of maintaining a child. Nevertheless, the fact that the allowance remains may be interpreted as official government sanction of large families. On the other hand, where countries have enacted legislation that permits allowances for only a certain number of children, this may exert a psychological pressure on families not to have more than that number of children.

Nurseries

There is an urgent need among working women for more nurseries. Child care continues to be viewed as the responsibility of the family and particularly of the woman. This places a great physical burden and psychological stress on the working mother. Public or private nurseries provided free or at low cost serve as an incentive to help mothers return to work. Most of the countries in the survey have some public nurseries but all indicate that they are insufficient to serve the population. Many private nurseries are so expensive that women, especially those with many children, must spend a large percentage of their salary on child care. In addition, many nurseries are far from the workplace, making it difficult for families to transport their children there.

Some countries have introduced legislation requiring industries with more than a certain number of workers (usually specified as female workers) to provide nurseries on the premises. In practice, many industries deliberately freeze the number of workers (or women) slightly below the mandatory number so that they are not legally obliged to offer this service.

Maternity protection

Maternity protection recognizes the legitimacy of childbearing for a woman while protecting her from employment discrimination. Most of the countries in the survey have legislation guaranteeing some maternity leave, protection from dismissal during pregnancy and the postnatal period except for good reason, and time off for nursing breaks.

In general, women are granted paid maternity leave under the social security system, although in some of the countries private employers or the government agency employing the woman also pay some benefits. In several countries legislation limits the payment of

benefits to women who work in the public sector only. This affects only a small number of women since the majority work in the agricultural or domestic sector.

The main international document in this area is the International Labour Organisation Convention on Maternity Protection, which calls for a minimum of 12 weeks' leave including 6 weeks after confinement, and prohibits dismissal during that period. At present not all of the countries in the Mediterranean region have legislation that complies with this Convention.

Although every country in the survey expressed a desire to provide maternity protection, a common concern was the cost and the loss of labour involved. Several countries indicated that it was particularly difficult for a pregnant woman to find a job.

Besides maternity protection, certain countries provide women with additional benefits, such as a delivery indemnity equivalent to a certain percentage of her monthly salary.

Land distribution

In Morocco, certain agricultural areas are owned by communes. This land cannot be bought or sold but is divided proportionally every year among the families living in the area according to the number of males in the family. This is an incentive for families to have many sons.

Income tax

All of the countries in the survey grant income tax reductions for families with children. In most countries, the taxes are progressive: the greater the number of children, the more the tax is reduced. This may also serve as a disincentive to practise family planning.

Country profiles

Greece. This is the only country in the study with an official pronatalist policy, and the recent decline in the rate of population growth has caused much official concern. Before the Second World War, a number of laws were introduced that could be viewed as supporting population growth. These laws were based more on humanitarian than on demographic concerns. They guaranteed large families (of five children or more), free education for the children, special tax exemptions, free medical care, housing, and exemption of the first son from military service.

After the Second World War, new family benefits were introduced including marriage payments of 5–10% of a man's salary, maternity benefits including US $50–200 for each delivery, and children's allowances of 3–6% of a person's salary. Every child born into a family with at least two other children receives a monthly allowance of 500 drachmas. Families with three or more children receive substantial tax benefits (6).

A woman working in the private sector receives 42 days' paid maternity leave before the birth and the same amount after the birth. Half of her salary is paid by her employer, and half by the social security system. Female public employees receive two months off before and two months off after childbirth. Women employed by the government are entitled to generous time off for breastfeeding: during the first two years of her child's life, a mother receives two hours off in the morning or the afternoon. When the child is between two and four years old, the mother can take one hour off a day.

There are insufficient nurseries in Greece, both public and private. In villages it is most common for grandparents to care for working women's children. Those who work in the public sector pay only a small fee for public day care, while those working in the private sector and using public nurseries must pay according to their means. Private nurseries are very costly so that only a small section of society can afford to send their children to them.

Italy. Italian women are entitled to maternity leave of two months before the birth and three months after. During this period they are entitled to all benefits and pay. In addition, a woman is entitled to take up to six months off without losing her job during the first year of her child's life (Act No. 1204 of 30 December 1971 on the protection of working mothers). From the beginning of her pregnancy until the child is one year old, the woman cannot be fired from her job without just cause unless the firm closes down, her work has finished, or the fixed term of her contract has ended.

While her child is less than three years old, the woman can take time off if she brings in a medical certificate indicating that her child is ill. If she takes this time off, however, she loses some benefits such as her annual leave and her Christmas bonus.

During the first year of the baby's life, the mother is entitled to take one-hour breaks a day. If she chooses, she can leave work early instead of taking the breaks during the day. If the child is in a crèche maintained on the premises by the employer, however, she is not entitled to leave her place of work.

Even if a woman is unemployed at the beginning of her pregnancy, she is entitled to a maternity allowance.

Agricultural workers are also entitled to maternity leave. In some instances they lose one half of their salary during this period, part of which is paid instead by health insurance. Since this does not make up the woman's full pay, it is more difficult for these workers to take the full time off.

There are some public nurseries in Italy but the number is insufficient to meet the needs of the population.

Morocco. Women are entitled to maternity leave of 12 weeks with pay, half of which must be taken after confinement. For 10 weeks, including the 6 weeks after confinement, half of the daily wage is paid by the social security system. Women also have the right to two half-hour breastfeeding breaks daily for one year after childbirth (Decree of 2 July 1947 to regulate employment and Dahir of 24 April 1973 to promulgate Act No. 1-72-219).

When Morocco was a protectorate, the French wanted to increase its population so they granted a children's allowance for as many children as a family had. Sometimes this allowance was equivalent to the main salary of the family. In 1958 the allowance was greatly reduced and the number of children for whom a family could receive it was fixed at six. Today, although the government's population goal is for a family to have no more than three children, the government still pays 30 dirhams a month per child for up to six children. This is a relatively small sum and Professor Mohamed Tahar Alaoui, Director of Technical Affairs for the Ministry of Public Health, does not believe it influences family planning.

The government provides some crèches but the number is limited.

Portugal. This is the only country in the survey whose Constitution recognizes maternity as of "fundamental importance" (Article 68 of the Portuguese Constitution). Medical assistance and medicine are free or cheap during pregnancy, birth and the period after birth for mothers and children. Working women are given a right to 90 days' maternity leave without loss of pay or benefits by Decree-Law No. 112/76 of 1976. They are given either full pay (in the case of civil servants) or an allowance equivalent to their wages (paid by the social security system). Working women cannot be dismissed (except for just cause) during their pregnancy or for one year after childbirth, as long as their condition is known to the employer. Mothers are allowed for breastfeeding two half-hour periods daily for nine months. The social security system provides a monthly feeding allowance in cash or kind, depending on whether the mother is breastfeeding or not, for the first eight months of the child's life. It also gives the family an allowance for each child. Workers are given a

certain number of days of paid leave each year to give urgent assistance to their family.

There is a shortage of nurseries and centres for the care and support of young children. In September 1978 there were 2116 public and private infant care centres. In 1977 free official pre-primary school education was established, for children aged three to seven, but in 1979–1980 only 406 classes with an average of 25 children per class were functioning.

Spain. Recent legislation granted women the right to take six weeks off work both before and after giving birth (Act No. 16 of 8 April 1976 on employment relationships). During this period they continue to receive the equivalent of their salary from the social security system. Women are also permitted one hour a day off for breastfeeding for nine months after their baby's birth. These requirements apply equally to government and private employers.

This same law also authorizes women to take three years' leave without pay after the birth of a child. Theoretically women are then entitled to return to their jobs, but in practice it is difficult for them to assert this right.

Spain grants a family allowance to protect large families and, since 1979, this has also been paid to single mothers of large families (Order of 22 June 1979 of the Ministry of Health and Social Services).

Spain has both public and private day care centres that children can be sent to when they are 40 days old. There are not enough public crèches, however, and private centres are very expensive.

The government recently made provision for creating funds to set up day care centres for children under six with no one at home to supervise them. This provision applies to the children of both male and female workers.

Tunisia. Women are entitled to one month's paid leave for childbirth. This may be extended by 15 days on the recommendation of a physician.

Women are entitled to two half-hour breastfeeding breaks each day during the first year of the child's life. A special room for breastfeeding is supposed to be set aside in every establishment that employs at least 50 women.

Family allowances are provided for up to four children. The law is regressive: the family receives less money for each child after the first up to a maximum of four children. The official government objective, which is communicated through official propaganda and the family planning services, is to encourage families to have two or three children. Each year a prize is shared among the three governorates with the best family planning programmes.

Tunisia has public nurseries but the number is insufficient. Many women who wish to work must place their children in expensive private centres in order to do so.

Turkey. The amount of maternity leave a woman is entitled to depends upon which law covers her type of work. The Labour Act No. 1475 of 25 August 1971 allows six weeks' leave prior to the birth and six weeks after it, while the equivalent law for civil servants permits three weeks before the birth and six weeks after. The inadequacy of this period is indicated by the number of women who apply for extensions based on medical certificates. Parents who adopt children are not given time off. Adoption is not a widespread practice and is permitted only when the couple are over 40 and have no children of their own (Civil Law, Paragraph 253).

There is a proposal to allow women two years off without pay after childbirth and the right to return to work, but this law has not yet been enacted.

Women are given one hour off a day for six months for breastfeeding.

Under the Labour Act, institutions with over 100 female employees are required to provide a nursery on their premises. In practice, employers tend to circumvent this provision by employing fewer than 100 women. The provision requiring nurseries for employees does not apply to women who are not covered under the Labour Act. The Minister of Health and Social Assistance has made a recommendation that the Department of Social Services lower the number of employees required before a nursery must be opened in a workplace, but this proposal has not been enacted. At present there are not enough nurseries and they are located in the large urban areas. In the rural areas most of the work is in agriculture; infants are carried into the fields on their mothers' backs and children begin to work at a very young age.

The law regarding family allowances is still pronatalist. People receive money for each child they have. Since the law is old, the sum of money is merely symbolic (about US $1 per month per child). The Ministry of Health and Social Assistance has proposed that the name of this children's benefit be changed in case the name is considered an inducement. Under some collective bargaining agreements, unions have received extra benefits for workers with children. At the request of the Ministry of Health and Social Assistance the unions have agreed not to call this a "children's supplement" any more and not to include the issue in future negotiations.

Child labour and social security

Legislation relating to child labour and social security also has an impact on family planning. In many countries large numbers of children are economic necessities. They provide manpower and financial security for their parents in their old age. Laws that prohibit child labour or set a minimum age for work may prove to be a disincentive for couples to have children for financial gain. Laws establishing a mandatory social security system may also help eliminate the need to have large families.

One disadvantage of this type of legislation is that it is costly. Without additional sources of revenue it is not realistic to expect developing countries, with limited resources and competing priorities, to offer all the services and programmes they consider desirable for their citizens. Yet some of this legislation is essential to implement a successful family planning programme.

All the countries surveyed have laws prohibiting children from doing certain types of work. They also have compulsory education for at least five years. In theory, the combination of these laws prohibiting child labour and requiring a certain number of years of schooling should keep young children out of the workforce. In reality, it is difficult to enforce these legal requirements.

In many areas neither birth records nor school records are kept properly. The correct age of a child often cannot be ascertained, making it difficult to prove that a child is legally under age. In addition, in many countries the labour laws do not extend to agricultural workers. Since many children work in the fields, often on small family-owned plots, they are excluded from coverage.

Finally, most of these laws do not include any type of penalty for violators, and even when penalties are specified they are rarely enforced. There is, therefore, little incentive for people to obey the law. In Tunisia, for example, the law prohibits children under 15 from working in industrial establishments. Children under 13 are also prohibited from working in agricultural production (Act No. 66-27 to promulgate the Labour Code of 30 April 1966). This law regulates both the number of hours children can work and specifies that they cannot do work that would be harmful to their health. There is little information available on how effectively these laws are enforced, but it appears that people are rarely prosecuted for violating them.

Turkey has a type of child labour that particularly exploits women. Children, usually girls who are orphans or members of poor families, may live with families, who use them as servants and make them work without pay in exchange for room and board. Although this practice (*besleme*) is declining, it still occurs in rural areas.

Education in Turkey is compulsory for five years, and therefore most children, even if they attend school for the required period, can leave by the age of 11. It is difficult to prevent them from working full-time after that age. At the moment there is a proposal to extend the minimum number of years of school from five to eight.

Spain prohibits minors under 16 from working, and those under 18 from working at night (Act No. 8 to promulgate a Workers Charter, 10 March 1980), but there are no criminal penalties for violators.

None of the countries in the survey has a social security system that is extensive enough to cover all senior citizens adequately. Even where coverage is comprehensive, the amount given is insufficient to meet basic living expenses. For example, Tunisia and Portugal provide all of their citizens with a small pension, but it does not cover normal living costs.

In some countries, social security coverage is limited to a particular section of society or differs according to the job a person holds. Some unions and companies have private insurance schemes that include pensions for their employees. Some countries only provide pensions for civil servants.

Turkey, for example, has three types of social security scheme.

1. *Sosyal Sigortalar Kurumu* (SSK) covers all employees with "worker status".

2. *Emekli Sandiği*. This scheme, started in the 1940s, covers all government employees and persons of civil service status.

3. *Bağ Kur*. This system, started in the 1970s, covers all self-employed and independent professionals. A 1979 amendment enables housewives who contribute to benefit. Since housewives are not working for pay, they must rely on their husbands to contribute to the system. If the husbands are reluctant or financially unable to pay, the women remain uninsured.

In addition to these three systems, some organizations have their own coverage. Many people are uninsured nevertheless. Both men and women who work in the agricultural sector, for instance, have no social security coverage, and 64% of Turkey's female population reside in rural areas and work in agriculture.

Even when all paid workers receive a small pension, women who have worked in the home or on the family plot without pay remain uncovered and financially vulnerable. In rural areas, many women do not receive compensation even when their husbands gain access to the social security system. For instance, some men work part-time as farmers and part-time in industry, and thus gain partial social security coverage. Their wives working on the land generally do not. Women are also employed on an irregular basis for one or two months a year or as clandestine workers. They may not realize that they are entitled to benefits and may not be informed about their legal rights.

Contraception

There are a number of international declarations that have recognized the central importance of contraception in the regulation of fertility. The 1968 United Nations Teheran Proclamation on Human Rights declared that family planning was a basic human right. This right was elaborated on in the 1969 United Nations Declaration on Social Progress and Development, which stated that the right to family planning included access to knowledge and to the means necessary for couples to avail themselves of that right. The World Population Plan of Action (*10*) that emerged from the United Nations World Population Conference held in Bucharest in 1974 reinforced the earlier conferences by recognizing the "necessity of ensuring that all couples are able to achieve their desired number and spacing of children" and recommending that all countries "ensure that family planning, medical and related social services aim . . . at the prevention of unwanted pregnancies".

Although these resolutions establish broad international principles, there are many legal regulations at a national level that can affect the right of the individual to obtain contraceptive services and information. The advertising, distributing and selling of the means of birth control are controlled by law, and the leniency or severity with which the laws are written affects the way contraceptives are supplied, distributed and used. Even where the legislation is good, the question remains whether the services actually reach the population.

In practice, it seems that even when contraceptives are illegal for family planning purposes, they are readily available in many of the countries for other uses: the Pill is prescribed to regulate menstrual cycles, the condom to prevent sexually transmitted diseases and the intrauterine device (IUD) to treat adhesions of the uterus.

Dissemination of information, advertising and promotion

In all the countries surveyed, the past four years have been marked by the increased availability of contraceptive services and information. Until quite recently, it was illegal in most of the seven countries to advertise or disseminate information about contraception. At present, however, the dissemination of information is no longer prohibited, and every country included in the survey permits some type of advertising. Despite the fact that all the countries wish to promote family planning, some continue legally to restrict the

advertising of contraceptives to medical journals or to permit displays of products in pharmacies only. This may limit the public's knowledge and, thereby, its use of contraceptives whereas unrestricted advertising of family planning methods would ensure their availability to a broader spectrum of society.

Country profiles

Greece. There is no special legislation concerning the distribution of contraceptives in Greece. All pharmaceutical products must be approved by a government committee, the State Laboratory for the Control of Pharmaceutical Products. No oral contraceptives are manufactured in Greece and none are tested locally by the government or private organizations, although many are available.

Up to 1980, oral contraceptives were not advertised as contraceptives but only for gynaecological purposes. In 1980, a special governmental commission advised that this restriction on the Pill should be removed and this recommendation has been followed. Until recently, condoms were promoted to prevent sexually transmitted disease.

Italy. Both the advertising and the promotion of contraceptives is permitted. The Italian Constitutional Court, in March 1971, declared unconstitutional Article 553 of the Penal Code (*Testo Unico degli Leggi Sanitarie*, Sections 112/1 and 114/1) which had prohibited the advertising of contraceptives. Law No. 194 of 22 May 1978, Section 22, repealed (among others) Article 553 of the Penal Code.

Morocco. The 1939 law that forbade the advertising and sale of contraceptives was repealed in 1967 by Crown Decree No. 181-66 of 1 July.

Portugal. The Constitution (Article 67, Paragraph d) gives the state the responsibility for promoting, by all necessary means, the wider knowledge of family planning methods and setting up legal and technical structures permitting planned parenthood. To further this goal, Decree-Law No. 542/76 of 9 June 1976 revoked the law forbidding the advertising of contraceptives in medical reviews. The authorization excluded abortifacient drugs.

Spain. Section 416 of the Penal Code forbidding the promotion and sale of contraceptives was amended by Law No. 45 of 7 October 1978.

Tunisia. The advertising of contraceptives to doctors, pharmacies and the general public is permitted only after a "visa" has been issued

by the public health authority (Law No. 61-7 of 9 January 1961).

Turkey. Advertising is legally unrestricted in Turkey, but hardly utilized. Contraceptives may be exhibited in pharmacies, and short announcements about the availability of prescription drugs are permitted with the approval of the Ministry of Health and Social Assistance.

Distribution and prescription

Even where information is readily accessible, laws requiring certain types of contraceptive, particularly oral contraceptives, to be dispensed only with a doctor's prescription limit their distribution.

Most of the countries in the survey require oral contraceptives to be prescribed by a physician. The rationale for this is that oral contraceptives are dangerous drugs which, if administered in an uncontrolled fashion, could pose a threat to health. Although the laws are in general agreement about the prescription requirement, there is some variation.

In Morocco, the Pill must be prescribed by a doctor the first time, but after that virtually anyone is permitted to resupply it. Contraceptives, including the Pill, are dispensed by physicians, nurses and midwives in both rural and urban health centres. In general, these personnel work under the supervision of a doctor. The Pill is also dispensed at local pharmacies.

In both Greece and Turkey, the Pill may be administered only by prescription, and in Turkey every type of contraceptive must be tested in the country before it can be approved.

In Spain, the Pill may be dispensed in pharmacies only. In Tunisia, doctors are allowed to sell medicine but only where there is no pharmacy within a radius of 15 km (Decree-Law No. 60-12 of 16 March 1960, Sections 29 and 31).

Although prescription is a legal requirement, these laws are largely ignored in every country studied. A government official in Spain described how, despite the prescription requirement for the Pill, in reality it is dispensed over the counter just as easily as aspirin. In large urban areas in every country, the Pill appears to be readily obtainable at pharmacies without prescription. Since every ministry responsible for health is attempting to encourage family planning, little effort is made to stop this practice although it is a technical violation of the law.

Drugs obtained over the counter are nevertheless often more costly than those obtained on prescription, and poor women may not be able to afford them. Furthermore, in some rural areas where pharmacies and physicians are geographically distant, women may

not have access to the Pill, making it unsuitable as a family planning method.

Some of the countries are attempting to lower the cost of contraceptives. Portugal, with a grant from UNFPA channelled through WHO, dispenses all contraceptives free to family planning centres. Tunisia and Turkey, with partial grants from UNFPA, also dispense contraceptives free. In Spain financial coverage for the Pill, as for other types of medication, is provided by the social security system; the woman pays 40% of the cost if she obtains it at a family planning centre. Many women, however, do not have easy access to a centre and therefore do not benefit from these government subsidies.

Insertion of the IUD

Although IUD insertion requires specially trained personnel, this does not mean that only a physician is qualified to perform the task. Morocco and Tunisia have used midwives to insert IUDs, and Portugal and Turkey are beginning to train nurse–midwives in this capacity, while Greece, Italy and Spain do not permit anyone but physicians to insert them.

One of the main reasons that IUDs have not been used more frequently is the lack of available manpower to insert them. Most of the countries in the Mediterranean region have expressed concern about this lack and are attempting to introduce new types of training programme. For example, a study was conducted in Turkey, under the auspices of WHO, whereby 200 midwives were given training and were permitted to insert IUDs and to administer injections. Although the results of the study are not yet complete, the initial reports have been so favourable that the Ministry of Health and Social Assistance has now proposed that the law be extended to allow skilled nurse–midwives to perform certain functions, such as IUD insertions, formerly reserved solely for doctors.

Tunisia has no legal restrictions on midwives inserting IUDs if they work in the public sector, and the majority of physicians have accepted the fact that family planning services are being provided by midwives.

Most laws do not specifically regulate IUD insertions. Despite this, many countries restrict the practice to doctors. Greece, for example, has no legislation on this point, yet the belief is that insertions are included under the medical practice act and must therefore be carried out by a physician.

According to Dr Albino Aroso, a former Secretary of State for Health and a family planning expert in Portugal, the biggest fight

should not be against the Church or the government but against doctors, because they are trying to keep a monopoly on family planning. He explained that, because of this protectionism by doctors, some family planning centres in Portugal do not insert the IUD. Many doctors do not have sufficient training to perform the procedure, others find it too time-consuming in terms of cost-benefit, while others have religious beliefs that oppose any type of contraceptive.

To make fuller use of midwives and nurses in this area, it is important to provide them with legal protection. At present, none of the countries surveyed covers them under its medical practice act. This act describes the kinds of activities that are the special domain of doctors, including making examinations and diagnosis, making out prescriptions and supervising treatment. The unauthorized performance of any of these tasks subjects an individual to criminal penalties. In some of the countries, paramedical workers inserting IUDs may be violating the medical practice act and be subject to prosecution. No one has yet been accused of practising medicine without a licence for inserting IUDs, but while these laws remain valid that possibility exists.

Furthermore, neither nurses nor midwives are authorized under present legislation to take the initiative in providing fertility regulation services. Nurses are usually required to work under the supervision of a physician, while midwives are not expected to perform family planning services as part of their jobs.

According to IPPF (*1*), without "some other form of specific authorization, professional health and auxiliary personnel may not have the *legal* authority under the laws as written to provide family planning services on their own initiative. The same is true for other types of non-doctor health personnel for whom no legislation exists – these would include, for example, the growing cadre of community-based family planning workers".

In Portugal and Turkey, to name only two countries, health personnel expressed a strong desire to have legislation introduced that would effectively cover nurses and midwives when they are providing family planning services.

Voluntary sterilization

Over the past decade, voluntary sterilization has become the most widely used means of family planning in the world. It is estimated (*11*) that almost 100 million couples or one third of all those practising contraception are using this method. Nevertheless, in the countries surveyed, voluntary sterilization is not a popular or widely

approved method of fertility regulation, in part because of its irreversibility. It is primarily available for medical reasons, either mental or physical. The laws in this region range from those that make voluntary sterilization a criminal offence to those where the legal status is unclear. Some countries have left voluntary sterilization unregulated. In Tunisia, although there is no legislation on the topic, sterilization is an acceptable family planning method after a woman has had all the children she wants, irrespective of the number.

None of the countries that allow sterilization permits anyone but a physician to perform the operation. In most countries sterilizations are performed in hospital, although in Tunisia they are also performed in family planning centres.

Even where there are no specific laws or regulations outlining the prerequisites that must be fulfilled before voluntary sterilizations can be performed, doctors have developed and closely apply their own requirements, which must be met before they will agree to perform the operation. These include a minimum age (generally over 30) and a minimum number of children (three or four). Most of the countries demand some type of informed consent, which ranges from a detailed written consent to informal verbal consent. In some of the countries the consent of the husband is required in cases of female sterilization; in other countries it is requested but not required. Male sterilization is rare in the Mediterranean region.

Greece. There are no specific provisions in the law. It is considered a crime to intentionally inflict corporal injury (Section 308, Paragraph 1 of the Penal Code; Law No. 1492, of 17 August 1950 on the Penal Code) but the injury is not unlawful if the injured person consented and the injury did not violate "good morals". In practice, the gynaecologist can decide according to medical indications if a sterilization should be performed. The doctor needs some type of consent from the couple but it does not have to be in writing.

Italy. The original Penal Code, predating the Second World War, prohibited sterilization under all circumstances. Article 552, Book II, Title X of the Italian Penal Code stated: "Whoever undertakes acts to make either a man or a women sterile with their consent shall be punished with imprisonment for not less than six months and not more than two years, and with a fine of not less than 40 000 lire and not more than 200 000 lire. Whoever consents that such an act be undertaken upon him or her shall be punished by the same sanctions". This Article was repealed, however, by Law No. 194 of 22 May 1978 on the social protection of motherhood and the voluntary termination of pregnancy (Section 22).

Morocco. As in most other Muslim countries, the legal status of voluntary sterilization is unclear. Many religious authorities interpret the law as forbidding sterilization, although it includes no specific provisions on this issue. In practice, sterilization is not performed unless the woman has three children and both husband and wife consent. If the husband does not consent, the operation is not performed. There are no vasectomies.

Portugal and Spain. In these two Catholic countries, sterilization is absolutely prohibited and considered a criminal offence. In practice, some sterilizations are performed.

The statute of physicians in Portugal prohibits the use of methods that lead to sterility unless the patient's life is endangered. Portuguese physicians have interpreted this as permitting such methods for medical reasons. The operation may, therefore, be performed if a sympathetic doctor can be located. All sterilizations are performed in hospital. Prosecutions of doctors are virtually unknown, the physician's word that the procedure is necessary rarely being challenged.

If a woman has five or more children and a serious health problem that would threaten her life, some Spanish doctors will perform sterilizations.

Tunisia. Although there is no official legislation, sterilizations are widely encouraged both in hospitals and family planning centres. President Bourguiba (*12*) has declared that medical sterilization is an acceptable form of family planning if a family has a sufficient number of children (i.e. four or more). In practice there is a medical consensus that a woman should be over 30, unless she has a medical reason for the operation, and that her children should not all be of the same sex. In 1980 some 8000 free sterilizations were performed.

Turkey. Sterilization is prohibited except for therapeutic reasons (Section 471, Paragraph 1 of the Penal Code). Sterilizations are allowed for a man or woman if either suffers from a hereditary disease, or for a woman if pregnancy would pose a threat to her physical or mental wellbeing. They are not permitted for family planning purposes (Decision No. 6/8305 of 12 June 1967). Sterilization of a married woman can be performed only with the consent of the husband. Each request for sterilization is considered by a committee of three specialists appointed by the Minister of Health and Social Assistance.

At present, the Ministry of Health and Social Assistance is working on a proposed bill to repeal the law on sterilization and to legalize the practice in most instances. The Ministry believes that sterlization is a woman's right. If the new bill becomes law, the only

restrictions on sterilization will be that girls under 18 will have to obtain the consent of their parents or guardians. The consent of the spouse would be requested but not required. There would be no requirements relating to age or number of children.

If this new bill were enacted, the Turkish law on sterilization would be the most liberal in the Mediterranean region and among the most liberal in the world.

Induced abortion

Among the countries in the survey there is a wide variation in the laws regulating abortion, from complete prohibition to abortion on demand. None of the countries recommends abortion as a family planning method; at most it is promoted as a necessary backup measure when contraception fails.

In every country with strict abortion statutes, experts estimate that there are a large number of illegal abortions and some abortions for medical reasons. In many of these countries, it is relatively easy for a woman with sufficient financial sources to find a physician who will perform an abortion. Few of these doctors or their clients are prosecuted. It is also common, however, for untrained people to perform this operation, often with disastrous consequences for the patient. Many abortions are performed in private homes or local clinics where good sanitary conditions are not required and modern equipment is not available. Women often attempt to induce their own abortions using traditional folk remedies. It is not uncommon for these women to require hospitalization owing to serious post-abortion complications. Some of them nevertheless are afraid to seek proper medical help, either because of the stigma attached to abortion or because they fear prosecution.

Laws regulating abortion generally include provisions as to who may perform abortions, where they may be performed and what type of consent is necessary. In none of the countries surveyed is anyone but a physician authorized to perform abortions. Abortions can always be performed in hospital, while in some countries, such as Italy, they are also permitted in outpatient clinics. Tunisia allows them to be performed in family planning centres. Most of the countries do not require the husband's consent to the abortion.

Country profiles

Greece. The vast majority of abortions are illegal. Abortion in most instances is punishable by a term of imprisonment of at least six months. A woman who induces her own abortion or who consents to an abortion is liable to a term of imprisonment of up to three years.

Abortions can be lawful in some specific instances. It is legal to obtain an abortion up to the 20th week to save the life of the woman or prevent serious and lasting injury to her health, and up to the 12th week to avert damage to her mental health. This must be certified by a psychiatrist working in a public health clinic. Abortion is also permitted up to the 20th week in situations where severe fetal abnormalities are ascertained through early fetal screening. Induced abortions are allowed in cases of pregnancy resulting from rape or incest, or from the seduction of a girl under 16. In cases where the life of the mother is in danger, a doctor other than the one performing the operation must certify the need for it. Legal abortions are not covered under any insurance system, and technically the woman must pay for the operation. Although abortion is largely illegal, experts agree that it is not difficult for a woman to obtain a safe abortion.

In a study (6) conducted by the Department of Hygiene and Epidemiology at the University of Athens, approximately one third of the married women interviewed reported having had one or more illegitimate abortions. This study also estimated that illegal abortions were responsible for approximately 40 % of the recent decline in birth rate.

Since most of the abortions performed are illegal, there is no law covering parental consent in the case of minors.

Italy. This country has recently undergone a great change in its abortion laws. Before 1975 abortion was permitted only in the case of danger to the life of the mother (Article 545 et seq. of the Penal Code). In 1975 a decision of the Constitutional Court held that this law did not accord with the Constitution. The Court decided that if a woman was physically or psychologically at risk, she could obtain an abortion. In cases of rape or incest the inherent trauma was insufficient; documentation of specific physical or mental harm suffered was required prior to the performance of an induced abortion.

In 1978, a new law (No. 194 of 22 May 1978) was introduced that expanded the grounds for abortion. Under this Law, a distinction is made between the first 90 days and the time thereafter. During the first 90 days the decision is entirely the woman's; she does not need the consent of the putative father. After the woman learns that she is pregnant, she must have a meeting with a doctor or a member of the staff of a family planning centre to discuss the matter. The purpose of the meeting is not to discourage the woman from obtaining an abortion, but just to talk over the situation. Then, if she wishes to obtain an abortion, she must wait an additional seven days before she can go to hospital to have the operation.

After the first 90 days, the choice is no longer the woman's alone; it becomes a medical problem. She must undergo examinations and is permitted to have an abortion only if there is danger to her life or if there is an indication that the pregnancy would be damaging to her physical or mental health.

After 180 days, the woman can have an abortion only if there is danger to her life. From a medical perspective, at this point the fetus can survive and the doctor then has a medical obligation to try to save its life.

The Law also includes a criminal part. If the woman does not consent to the abortion, the person performing it is subject to a term of imprisonment of 4–8 years. There are also punishments if the abortion is performed by a non-medical person. Perhaps the most novel part of the new Law is the provision for punishment if the abortion is committed in contravention of rules for the protection of labour, for example if the abortion is a consequence of trauma at work. In practice, no one has been prosecuted under these provisions.

In 1981 a referendum on abortion sustained the 1978 Law.

Morocco. Abortion is generally illegal except when performed to safeguard the health of the mother. The consent of the husband is usually required. Anyone who performs an abortion is subject to a term of imprisonment of 1–5 years and a fine. Those who habitually perform abortions are subject to double the punishment. Moroccan Muslims believe that life is sacred after conception. In practice, there are a large number of illegal abortions in the country, and there have been no prosecutions for violations of the law.

Portugal. Abortions are forbidden in general unless they are necessary to save the life of the pregnant woman. Abortion is punishable under the Penal Code with a term of imprisonment of 2–8 years. If the woman has committed the offence to "save her dishonour", she is subject to a shorter term of imprisonment (Section 358 of the Penal Code and Decree of 16 September 1886 as amended). It is estimated that 100 000 illegal abortions are performed each year.

Spain. One of the most restrictive laws in the Mediterranean region exists in Spain. Abortion is generally illegal and violators can be punished with six months to six years of imprisonment. Doctors and midwives who perform abortions are subject to harsher penalties. Legally, abortion is permitted only to save the life of the mother (Sections 413–415 of the Penal Code, revised text of 1963, promulgated by Decree No. 691 of 28 March 1963). In practice, it is estimated that 300 000 abortions are performed illegally in the country each year. In addition, many women travel to other countries where abortion is more freely available.

Although there are few prosecutions for abortions, people are occasionally arrested and tried. This generates a great deal of public debate. In June 1981 eight people, both those performing abortions and their clients, went on trial in Bilbao.

Tunisia. This country has one of the most liberal laws on abortion in the Mediterranean region. Abortion on demand is permitted within the first three months of pregnancy; thereafter abortions are allowed to preserve the health or mental balance of the mother or if it is likely that the unborn child will suffer a serious infirmity. Abortions must be performed by a doctor in a medical establishment. Every region in the country has a family planning centre and all these centres perform abortions and offer family planning services.

Unlike in Morocco, only the consent of the woman is required. All abortions performed in medical centres are free. Although abortions are officially permitted, they are not considered a primary family planning method; the health ministry views abortion as a failure of contraception. In 1980, 20 000 abortions were performed.

The Tunisian law has changed in a gradual fashion. Before 1965 the law permitted therapeutic and social abortions, after the birth of five children. The present law was liberalized in 1973.

Turkey. The 1926 Turkish Penal Code, adapted from the Italian Penal Code of that period, considered induced abortion a crime. An amendment to the Penal Code introduced in 1936 increased the penalties for induced abortion and penalized any attempt to avoid conception. The 1936 amendment also changed the title of the relevant sections of the Penal Code from "The crime of induced abortion" to "Crimes against the integrity and health of the race". In 1953 the penalties for abortion were increased again.

Today, abortion is generally illegal in Turkey and anyone who performs an abortion is subject to imprisonment for a period of 2–5 years. A woman who induces her own abortion is subject to imprisonment of 1–4 years and if she consents to having an abortion performed by others, from 1 to 5 years. (Law No. 765 of 1 March 1926 as amended by Law No. 557 of 1 January 1965, relating to Sections 136 and 137 of the Penal Code.)

Termination of pregnancy is permitted if the life of the mother is endangered or likely to be endangered by the pregnancy, if there are abnormalities in fetal development or there is a risk of hereditary defects, or where pregnancy is the result of rape or incest. Abortions may not be carried out without the consent of the pregnant woman, or of her guardian or the court if she is a minor.

The Ministry of Health and Social Assistance is in the process of

drafting a new law that would liberalize abortions considerably. If the law is passed, abortion on demand will be legal during the first trimester.

One of the reasons for the proposed abortion reform is that the practice of abortion appears to be widespread regardless of the law. One study (*13*) indicated that one in five pregnancies were aborted. The Ministry estimates that there are 500 000 illegal abortions performed every year, resulting in 7500–10 000 maternal deaths. Yet only 10–15 people are convicted each year of having performed or obtained an illegal abortion.

If the proposed abortion law is adopted, it will not be introduced as a new family planning method. Rather, it is being defended as supporting a woman's right to control her own body. Additionally, the Ministry believes that unwanted children do not have the same opportunities for health and social wellbeing in society as do planned children.

Conclusion

As can be seen from an examination of the practices in these countries, women frequently resort to abortion even where the practice is illegal. One reason for this is that many women do not have access to other types of contraception. Although every country in the survey has legalized the use of contraceptive methods, their distribution is still inadequate. Many regions of a country do not have clinics or adequately trained staff. Information is not readily available, and peer group pressure or religious influences often deter women from obtaining advice about the proper usage of contraceptives.

TEENAGERS AND FAMILY PLANNING

Family planning services

Although every country in the survey has introduced family planning services for its adult population, the question of whether these services should be extended to adolescents is controversial. The debate ranges from those who believe that introducing sex education or family planning services could encourage the young to experiment sexually or undermine religious and traditional values, to those who believe that unwanted pregnancies and sexually transmitted diseases among the young are social realities that must be confronted in a straightforward way.

Under the laws of all the countries surveyed, people do not become capable of making independent decisions that are binding under the law until they reach the age of majority. That age varies from 15 to 18 in these countries; until that time, a person is considered a minor or an adolescent.

In many of the countries surveyed, the law does not permit minors to obtain family planning services without the consent of their parents or guardian. Minors are considered to lack the legal capacity to make an informed decision about medical treatment. Since family planning services, like appendectomies, are considered medical in nature, the same legal requirements apply. The rationale for this type of law is commendable. It is to protect young people from hasty decisions and poor treatment. Unlike other types of medical treatment, however, the reality often means that teenagers are deprived of the option of obtaining proper information or access to services. Many adolescents may feel that this is not a subject they can discuss openly with their parents and choose to "go without" rather than seek their permission. Parents often do not realize (or refuse to admit) that their children are sexually active and would not permit them to seek professional help even if they did know. Although the parental consent requirement might deter a few adolescents from engaging in premarital sexual activities, it is likely that many will simply have intercourse without taking the necessary precautions and risk unwanted pregnancies.

Some family planning centres in areas with this type of legal restriction ignore the law and provide a service to anyone who comes in for help. They often express concern, however, that some young people will not ask for assistance because of their fear that they will be turned away. Their fear is often justified, as other centres follow the law strictly and refuse to offer their service to adolescents.

Spain offers examples of both attitudes. Theoretically, people under 18 must obtain parental consent before they can receive family planning services. In some public centres, however, everyone is served with no questions asked. In other more conservative regions, adolescents in the same circumstances are turned away.

The situation differs slightly in Portugal. The age of majority is 18 and, theoretically, parental consent is required before that age. If a girl marries at 16, however, consent is not necessary.

Voluntary sterilization

Voluntary sterilization is not available to adolescents as a family planning method in any of the countries surveyed, and most of them lack any legislation on this issue. Medical practice generally requires

that a person wishing to be sterilized has a certain number of children, and/or is a certain age, usually over 30. Although teenagers may have the requisite number of children, doctors will not normally perform the operation on them because of the age requirement. There are medical exceptions to these requirements but in general, the physical health of the person must be severely threatened or the person must be proved mentally incompetent. Under such circumstances, there is usually a requirement that the permission of the parent or guardian must be obtained prior to the operation. In cases where there is an issue of mental incompetence, legislation in some of the countries requires that a committee be appointed to make the decision.

Induced abortion

None of the countries surveyed, that permit abortion, have any legislation specifically dealing with abortions for adolescents. The same legal requirements therefore apply to minors as to adults. If abortion is permitted for medical reasons only, then minors are held to the same standard. The consent requirement may, however, make abortions even more difficult to obtain for adolescents than they are for adults.

Italy, for example, with a liberal abortion law, requires girls under 18 to obtain the consent of both parents. If one of them does not wish to consent, or if the girl does not want to go to her parents, she can apply to a judge for this permission.

In practice, many young girls do not wish to comply with these legal requirements and obtain illegal abortions instead.

Sex education

In some parts of the world, especially the Scandinavian countries, sex education is mandatory in schools. In the countries studied, however, sex education has not been integrated into primary or secondary school curricula. In some of them, sex education is provided in biology classes; in others, there is limited discussion about contraception as part of a general course on family life. None of the countries surveyed, however, includes sex education courses as such.

At present, there is no legislation in any of the countries surveyed that expressly prohibits sex education. Neither is there a strong government policy that promotes or advocates the teaching of these subjects in schools. In large part, this is due to the religious and

cultural values of many of these societies. Officials in countries with strong religious traditions, such as Morocco, expressed strong disapproval of sex education in schools.

At present, it would be difficult to integrate sex education into a school curriculum because most teachers have no training in the area. One teacher in rural Turkey, when asked if he taught sex education in his classes, replied: "What would I teach?" Several countries are beginning to offer courses in sex education in teacher training schools or at university. Most, however, do not even offer courses in this area to their medical personnel.

Because there appears to be strong opposition to the introduction of fertility-related education in most of the Mediterranean region, it is unlikely that the governments will alter their policies unless it becomes necessary to do so to curb population growth.

Since many people do not stay at school for a long period, it is also important to provide adolescents with sex education in more informal ways. The media are being used more and more frequently to discuss family planning information. Portuguese television recently transmitted a half-hour programme giving information to young people on family planning. Moroccan television has developed a sophisticated type of advertisement complete with jingle that depicts the benefits of small families. Some Portuguese family planning clinics have developed cartoons and other visual material to teach clients about contraception. More of these techniques need to be developed in the future if adolescents are to be reached.

Country profiles

Greece. There is no law on sex education in Greece and courses are not required in schools. During a recent two-day symposium on the topic, recommendations were made to provide sex education in schools but the government has not acted on these proposals. Family planning is so new in the country that little work has been done to make information and education available on a broad scale to adolescents.

Italy. There is no law about the provision of sex education. Some schools, especially those with large Catholic populations, avoid giving any type of sex education apart from teaching about human reproduction in biology classes. Many government family planning centres, however, do offer courses in sex education.

Morocco. There is no sex education in Moroccan schools, although science courses teach young people about human reproduc-

tion. Government officials indicated that many people over forty think it is embarrassing to provide sex education in schools. The government does, however, have a campaign, through the use of the media, to help people understand the benefits of family planning.

Portugal. Although courses in sex education are not offered in schools at the moment, an active project on family planning information, education and communication is being implemented by the Government Commission on the Status of Women and funded by UNFPA. This project has worked closely with radio, television and the press to offer information on sex education and parenthood, and also on where family planning services are available.

The Family Planning Association with UNFPA funding, is planning to introduce courses in sex education into the secondary school curriculum. According to Dr Albino Aroso, Director of family planning services at the General Hospital of Santo António, in Porto, there is a problem about who is qualified to offer sex education courses, especially the psychosocial aspects, since doctors are not prepared to provide this information. He pointed out that teenagers are often hesitant to go to meetings because they are afraid their parents will know and that it is also difficult to find people who can establish a good rapport with teenagers.

Spain. An attempt by the Minister of Education to introduce sex education into primary schools in 1980 came to nothing. Spain has few ways of disseminating information on this subject.

Tunisia. There are no specific courses in sex education. In primary and secondary schools, however, sex education is integrated into courses on population. Biology classes teach human reproduction and mathematics classes often use demographic problems to raise the issues with students in a different form. In 1980, UNFPA began giving funds to the Ministry of Education to establish some courses and to integrate information about sexual matters into the primary school curriculum. A priority for the government in this area is to transmit information to those who do not attend school.

Turkey. Teenagers can receive family planning information and contraceptives without parental consent. There are no education programmes in the population field in primary or secondary schools, and teachers are not offered courses in this area. Premarital counselling is rare. The Directorate-General of Population Planning, a division of the Ministry of Health and Social Assistance, is permitted to offer information on population planning through magazine articles, films, lectures, exhibits and direct contact with the public. The government has indicated a particular interest in

improving educational and training activities in family planning. There are discussions about developing the teaching of family planning in medical schools and integrating the subject into health education courses at the lower school level.

PART II

COUNTRY PROFILES

GREECE[a]

Among the countries surveyed, official family planning programmes have been introduced most recently in Greece. It is also the only country investigated that has a declining population growth rate.

The decline in population growth began in the 1930s, but because statistical accounts were incomplete, it was only around 1960 that this fact became known. Studies carried out during this period showed that the low birth rate could be explained in large part by the wide practice of illegal abortion (about 75 000 a year among married women and an equal number among single women). Greece has also had a large wave of emigration, many of those leaving for indefinite periods of time being young men of marriageable age who go to other European countries to seek work. It is common for them to remain unmarried until they return home.

These demographic issues – low fertility rates, high abortion rates and substantial emigration – concerned the government sufficiently in 1968 for it to appoint an ad hoc committee on demographic policy. This committee, consisting of government officials and members of the medical community, was charged with studying the Greek population problem and proposing corrective measures.

At that time there was no legislation specifically aimed at demographic issues. There was some legislation dealing with maternal and child health, such as provision for four months maternity leave. There was also legislation concerning family assistance, based on humanitarian considerations, that provided marriage payments, maternity benefits, child allowances and tax benefits.

The ad hoc committee made several proposals:

- to found family planning units throughout the country, each unit serving as a consultation centre for marriage, birth, fertility and sterility problems;

[a] Much of the information in this section comes from Trichopoulos & Papaevangelou (6).

- to educate the public on the basic aspects of reproduction;
- to decentralize the health services and to create additional maternal and child health units in rural areas;
- to prevent migration through decentralization, the creation of new job opportunities and the introduction of various economic measures; and
- to develop new legislation favouring an increase in the birth rate.

In 1970, after new statistical data had been analysed, it was apparent that the birth rate had dropped to its lowest point in modern history and that the emigration rate had risen to one of its highest. Furthermore, there was evidence of substantial migration from rural to urban areas with a consequent decline in the rural population. Based on this information, the population policy formulated at that time called for higher birth rates, lower emigration rates, and decentralization and redistribution of the population. This policy continues to be the official one today.

As a means of decentralizing the population, the country was divided into a series of relatively autonomous areas, each with control over its own health services. To encourage population growth, Decree-Law No. 1153, enacted in 1972, granted a monthly allowance to every family with three or more children. They also received greater tax benefits. Some people believe, however, that the real solution to the problem is halting migration, not encouraging fertility.

Family planning legislation was introduced in 1980 (Law No. 1036 of 15 March 1980) to combat the extremely high number of illegal abortions. A seven-member Family Planning Advisory Committee was established in the Department of Health within the Ministry of Social Services to deal with questions of family planning policy. The Law calls for the state to take care of the dissemination of information and the practical application of family planning.

At present, there are five family planning centres in the Athens area, one in Salonica and one in Ioannina. These centres are still limited in scope and lack good organization. Initially, some concern was expressed about whether a family planning programme and an official policy of encouraging population growth were mutually exclusive goals. The Ministry of Social Services does not believe they are, since the main purpose of the family planning programme is not to curb the population but to enable couples to control the number and spacing of the children they desire. This type of planning is not inconsistent with population growth.

Since modern aspects of birth control are not included in medical school curricula, a knowledge of fertility control and contraception is limited among practising physicians. The Family Planning Advisory

Committee has started to hold training seminars for medical and paramedical personnel.

There is no special legislation on the importation or distribution of contraceptives. Most contraceptive methods have been introduced since 1962, but their use is limited. No oral contraceptives are manufactured in the country. It is estimated that in 1980, 0.8% of women aged 15–44 years used the Pill and 0.7% the IUD. Sterilizations are rarely performed. According to Dr John Danezis, President of the Family Planning Advisory Committee (*14*), Greek doctors are not oriented towards this type of operation, in part because of its present irreversibility.

Illegal abortion continues to be widespread. Law No. 821 of 13 October 1978 expanded the reasons for therapeutic abortion to include serious abnormalities of the fetus and proven major psychological disturbances in the pregnant woman. Abortions for social or economic reasons continue to be forbidden.

Recommendations

1. The ad hoc committee recommended educating the public on the basic aspects of reproduction. Legislation should be introduced that would allow the provision of sex education in schools.

2. Legislation should be introduced to permit the official recognition of existing family planning centres and the creation and distribution of others on a geographical basis.

3. Although the use of contraceptives is permitted in practice, regulations should be drafted to actually legalize their advertising, distribution and use.

4. The estimated high number of illegal abortions indicates that, regardless of legal restrictions, abortion practice is widespread. The law should be changed to reflect the existing reality in the country. At present, only abortionists benefit from the restrictive laws because they can charge high rates to perform the operation. Legalization of abortion would ensure that women received safe treatment at reasonable prices.

5. At present, family planning activities are not covered by the insurance organizations or by the general public health organizations. Laws should be written to include family planning activities under these types of coverage.

6. Legislation should be drafted to permit the entire population to receive social benefits, such as maternity protection, guaranteed old age pensions and unemployment pay as appropriate.

7. Legislation should be drafted requiring workplaces with more than 50–100 employees to provide nurseries.

ITALY

Under fascism, the law and population policies in Italy were pronatalist. Abortion, contraception and sterilization were prohibited and penal sanctions were imposed on violators. Both the Catholic Church, which opposed any type of artificial birth control, and the fascists, who desired to increase the population for military purposes and to maintain traditional values by keeping women in the home, encouraged people to have large families.

In 1971 the law prohibiting the advertising of contraceptives was abolished. This was a first step toward government intervention in family planning. It was not until 1975, however, that the first law was passed creating official family counselling centres (Law No. 405 of 29 July 1975). For 20–25 years before that date, only voluntary organizations had been involved in this field. During the same year there was a reformation of the Civil Code as it affects the family, the age of marriage being changed to equalize the position of men and women. Previously, girls of 14 and boys of 16 were allowed to marry. After the reform, the age was set at 18 years for both sexes. Minors of "sufficient maturity" can marry at 16 years of age. A consultation service meets those aged between 16 and 18 years who wish to marry, and determines whether they are capable of making this decision.

The family law reform also extended to illegitimacy. Before 1971, a married woman could not claim that her husband was not the father of her child. Today, she can go to court and challenge her husband's paternity on the basis of blood tests and other scientific evidence. Furthermore, a married man can acknowledge another woman's child as his own. Before the reform, this was forbidden.

Contraceptives were effectively legalized in 1975, but it was unclear whether abortion and sterilization were legalized at the same time. It was three years later, in 1978, that Law No. 194 of 22 May clearly legalized abortion. It remains debatable whether sterilization is legal today. Because of this apparent gap in the law, doctors make decisions about sterilization on a case-by-case basis.

The issue of abortion has been reexamined twice in the past few years. Before 1975, abortion was permitted only in cases of danger to the life of the mother (Penal Code, Article 545). In 1975 the Constitutional Court decided abortions were permissible if the pregnancy was harmful to the mental and physical health of the woman. It was following this court decision that Law No. 194 on the social protection of motherhood and the voluntary termination of pregnancy was passed in 1978. The major part of the Law dealt with abortions. A distinction is made between abortions performed in the

first trimester and those performed thereafter. During the first 90 days, the choice of having an abortion is left exclusively to the woman. No reason is required. After that period abortion is considered a medical problem; it must be performed in a hospital and can only be performed for health reasons. A 1981 referendum confirmed this Law.

Section 22 of the Law decriminalized sterilizations. Nevertheless Dr Benciolini, Professor of Forensic Medicine at the University of Padua, indicates that many doctors believe there is no law on this issue, and that if they sterilize someone they do so at their own risk. This may inhibit them from performing the operation.

In Italy today, there are both public and private family planning centres. The public centres are required by law to be staffed by competent people, including a doctor (usually a gynaecologist), a psychologist, a social worker and a paramedical worker. In general, the centres perform two functions: counselling at the individual level and prevention, including discussions with students and health service workers about sex education and contraception. Although there is no law about sex education in the country, many centres offer courses in this field. Services are free.

In general, people come to the public centres to receive information about abortions and contraceptives, the latter being fitted only by doctors. Nurse–midwives are not used as a resource in this field. The public centres must display all forms of contraceptive, while the private centres have no obligation to do so. In reality, many family planning centres are private and Catholic and advocate only natural methods of birth control. Furthermore, although abortions are legal, many doctors refuse to perform them and they are under no legal obligation to do so. In certain parts of the country that are more conservative, therefore, abortions are difficult to obtain.

Over the past decade or so Italian society, formerly very traditional, has undergone profound changes, some of which have been quite disruptive. Divorce became legal in 1970. Laws on abortion, contraception and family planning centres have been promulgated. The next and perhaps even more difficult step is to ensure that these laws are implemented and that people all over the country, in both rural and urban areas, have access to information and services on fertility regulation.

Recommendations

1. Legalisation should be introduced to permit nurses and midwives to insert IUDs and to receive the same protection as doctors receive under the medical practice act.

2. Doctors should be informed that sterilization has been decriminalized. Guidelines should be written to indicate what is necessary before the operation is performed; for example, informed consent should be required.

3. Under the new law for the termination of pregnancy, health personnel are not required to participate in the procedure if they are conscientious objectors and state so in advance. (In general, they are required to indicate this when they commence employment.) Although health personnel have the privilege of following the dictates of their conscience, women who wish to have abortions have the legal right to do so. This right is therefore meaningless if there is no one who will perform the operation. It is possible that in some parts of the country it would be very difficult for a woman to find a willing doctor. Japan has resolved this problem by licensing special doctors to perform abortions. Lists are published of the names of these physicians so that women know where to locate a doctor willing to perform an abortion. This saves the woman from the humiliating experience of being turned down by several doctors and eventually giving up in frustration. Italy could adopt a similar type of legislation which would ensure that the law was implemented.

4. The law should require workplaces with more than 50–100 workers to provide nurseries.

5. Social benefits should be provided for the entire population as appropriate. Maternity benefits should be given equally to all women regardless of their employment. At present, agricultural workers are not entitled to full pay during the period in which they qualify for maternity benefits. This may prevent some women from taking the full time off.

MOROCCO[a]

Under French rule, Morocco followed a pronatalist policy and many laws were introduced to support this approach. Child allowances, maternity benefits and tax reductions for each child were among the incentives offered to people to produce more children. Large families were also popular because of the high infant mortality rate, the lack of pension benefits in old age and the unstable economic situation.

[a] Much of the information in this section comes from *Proceedings of the Symposium on law and population in the Middle East and North Africa, Cairo, 7–10 December 1976* (9).

The annual population growth rate of 1.57% in the 20-year period 1932–1952 rose sharply to 3.1% in the six-year period 1971–1977. According to Dr Mohamed Bouzidi, Regional Director of IPPF, Morocco is one of the Third World countries that double their population every 25 years: the population increased from 9 million in 1952 to over 18 million in 1977.

The government did not introduce a family planning programme immediately after independence. At the request of the government, however, an economic survey of the country was conducted in 1964–1965 by the World Bank. The report recommended a reduction in fertility as a means of curbing population growth. In order to accomplish this goal, the report made several suggestions including raising the age of marriage for girls from 15 to 18 years of age, changing the system of family allowances, introducing birth control and starting a family planning programme. During this same period, other reports and statistical information were also indicating the need for the government to become involved in a systematic way in fertility reduction. In 1966, a royal decree set up a national commission and several regional commissions to develop a family planning programme and to create family planning centres.

By mandate, this national commission was to meet four times a year to review policy in this area, but it has held fewer than 15 meetings since 1966. At that time there was no consensus about introducing family planning, although the law authorized it. From the start, the commission encountered opposition from various segments of society and this may account for its lack of active participation in the area.

In 1966 the importation, manufacture, advertising, distribution and use of all types of contraceptive were legalized, Since then they have been distributed free of charge in government family planning centres.

The Ministry of Public Health also issued a memorandum that year stating that the goal of family planning was to allow those families that felt the need for family planning to obtain the size of family they desired in a way that did not affect the mother's health (through repeated pregnancies). This should also help families to give their children a good education and create a physical, mental and social equilibrium in society. The memorandum also stressed that contraception must be voluntary. Following the issue of this memorandum two oral contraceptives, Lyndiol and Previson, were introduced in the country.

Family planning has been included in the five-year development plans of the government since 1968. The first five-year plan (1968–1972) attempted to provide 500 000 women with contraception but this goal was not reached. In 1968 family planning centres were serving

400 women a month. By 1972 they were receiving 700 a month or around 10 000 a year. Most of the women seen were urban middle-class women. Some 68 500 IUDs were inserted during this five-year period, far short of the goal of half a million. Contraceptives are available in Ministry of Public Health facilities, but their distribution is limited. Several surveys have shown that rural women come to planning centres only after they have had three children and are over 25 years of age.

Prime Minister Ahmed Osman (*15*) stated in November 1978: "Our annual growth rate of around 3 per cent could lead to catastrophic repercussions . . . The galloping demographic increase is in effect a burden on the family and on the state . . . ".

The 1973–1977 development plan adopted a crude birth rate target of 35 per 1000 by 1985. A new objective to introduce 390 000 women to fertility regulation devices was met. The numbers of women using the Pill and the IUD increased. In 1978, 5865 IUDs were inserted in public clinics and in 1979, the number increased to 14 219. The number of pregnant women who visited the clinics also increased from 109 244 in 1974 to 133 122 in 1979. Even so, not more than 5% of pregnant women pay prenatal visits. At present, approximately 10% of women between 15 and 44 years of age are using contraceptives. The goal during the next five-year plan (1983–1987) is for 24% of women to begin using contraceptives. About 90% of women now using contraceptives take the Pill and 7–8% use the IUD. Although abortions in most instances are illegal, a large number are performed each year. According to Professor Mohamed Tahar Alaoui, Director of Technical Affairs for the Ministry of Public Health, many women have numerous abortions instead of using contraception. At this time, the reality is more advanced than the law.

The main objectives of the Ministry of Public Health are to increase public understanding of the issues surrounding population control. Professor Alaoui stated that the main goals of the Ministry were the improvement of health and individual quality of life. Its work is to try to convince people to have three children instead of the six or seven they are currently having and to help the country develop better.

Once the political programme is developed, the services must be provided for those who want them. At present Morocco suffers from a shortage of qualified medical personnel. Nurses and midwives are slowly being trained to insert IUDs, but the Ministry believes that these projects must be planned carefully or the population will reject them. Unless people are well prepared, they are sometimes hesitant to trust non-physicians to provide medical assistance.

At present, many of the social benefits allotted to families are

restricted to civil servants and industrial workers. Domestic and agricultural workers and those who are unemployed are generally not included in these payments. For example, only civil servants and industrial workers are entitled to maternity benefits.

Recommendations

1. Legislation should be introduced permitting midwives and nurses to insert IUDs and providing them with the same protection doctors receive under the medical practice act.

2. Abortion is a complex problem in Morocco. There is a dispute in the Muslim religion about whether life begins at the time of conception or only when the soul emerges after the first trimester. Many authorities believe it would be difficult to liberalize the laws at present. Current legislation protects the physician by permitting him to decide if the women's health is in danger.

3. There is no legislation on sterilization, but there is a general consensus that the consent of the husband is needed if the wife desires the operation. Legislation should be introduced that would leave this decision entirely up to the woman concerned. The consent of the partner could be requested, but the operation should be performed even if that permission is not granted.

4. Incentives that encourage large families, such as a family allowance for up to six children, should be abolished. Families that already have six children should continue to receive their subsidies so that the children will not be penalized, but new legislation should be introduced that would limit the family allowance in the future to three children.

5. Social benefits, including old age pensions and maternity benefits, should be paid to everyone as appropriate. This would help to end the apparent necessity of having large families to insure people against indigence in their old age.

6. Legislation should require companies employing more than a certain number of people (say 50–100) to provide nurseries on the premises.

PORTUGAL[a]

Of the countries studied, only Portugal considers family planning a constitutional right. The Constitution of the Portuguese Republic of

[a] Much of the information in this section comes from the Ministry of Social Affairs and from the Commission on the Status of Women (unpublished data).

2 April 1976 declares that the state is responsible for promoting, by all necessary means, the wider knowledge of family planning methods and setting up legal and technical structures permitting planned parenthood (Article 67, Paragraph d). Official policy considers family planning a means of improving maternal and child health, not a factor of population policy.

Before the revolution in 1974, the Salazar régime was pronatalist in its family planning policy. The use, advertising and distribution of any type of contraceptive was prohibited. Despite this official government policy, family planning activities had already begun in Portugal during that time. Some groups of Catholic couples were already providing information on family planning by natural methods around the country. They formed a self-help group, Serviço de Entre-Ajuda e Documentação Conjugal (SEDC), which is still active and affiliated to the International Federation of Family Action. The first nongovernmental family planning organization, Associação para o Planeamento da Familia, was founded in 1967 by a group of doctors, priests and Catholic couples. Its charter states that the Association aims at cooperating with Portuguese families, especially with those from lower income groups, so that a responsible planning of births can be made in each particular case. The Association has tried to raise the government's interest in the issues surrounding family planning.

The first family planning service was organized in Porto in 1969 under the supervision of Dr Albino Aroso Ramos. In 1973, the Directorate-General of Health decided that family planning services should be available in 20 maternal and child care centres around Porto and Lisbon. Although many other aspects of medical care were provided for under the social security system, family planning services were not covered. This continues to be the case today.

Most existing family planning services were introduced after the revolution in 1974. In 1976 Dr Aroso Ramos, as Secretary of State for Health, ordered that every health centre, as far as technically possible, should set up a family planning service and integrate it with maternal health care. One reason he gave for this directive was that there was and is a very high incidence of induced abortion, with disastrous consequences for maternal health. Another reason was that contraceptive methods were being used without proper counselling, creating various problems. During this same period, Decree-Law No. 542/76 revoked the law forbidding the advertising of contraceptives in medical journals, which was held to be fully divorced from the realities of present day life and from the idea of contraception itself.

Family planning services were made available in health centres throughout the country. At present there are about 280 family planning services and 250 are integrated with mother and child care

services. Family planning services are free of charge and, through a grant from WHO, contraceptives distributed through family planning centres are also free. The user's choice of contraceptive is respected. Contraceptive methods available to the public are the hormonal, mechanical and chemical types.

According to Dr Aroso Ramos, the Portuguese Medical Association has a very powerful lobby. Although there is no law regulating IUD insertion, in practice only doctors insert them. Furthermore, many doctors refuse to insert them, some for religious reasons (they consider the IUDs to be similar to abortions), some because they have not received training in how to insert them, and others because they feel insertion takes too much of their time. This means that in rural areas, where there are no doctors readily available, women may not have the opportunity to use this form of birth control. In Porto, one midwife has been trained to insert IUDs.

Although the diaphragm is not a common form of birth control in Portugal, nurses and midwives can measure a woman for it and it can be purchased without a prescription at pharmacies. The Pill, like other types of medication, should be prescribed by a physician, but in reality a woman can purchase the Pill freely at a pharmacy if she knows the pharmacist. Some women use contraceptives without their husbands' knowledge. Teenagers under 18 years of age are prohibited from using family planning services at the centres unless they are married. Teenage pregnancy is a problem in Portugal and adolescents often receive no help or counselling during this period.

Abortion is illegal and punishable by 2–8 years' imprisonment. Nevertheless, it is estimated that over 100 000 illegal abortions are carried out each year. Fewer than eight people are prosecuted yearly. Dr Aroso believes that if abortion were legalized, married women would obtain them but teenagers still would not. Especially in the northern part of the country, which is very conservative, women would not like it to be known that they desired an abortion and therefore would not go to hospital to obtain one. He cited Poland as an example of why he believes legalizing abortions would not increase the number of women who seek them legally: although Poland is a conservative country, like Portugal, abortions there are legal, yet only 200 000 abortions are performed legally every year and 1 million illegally. He believes, however, that everything will change in the next five years because of the new attitudes of young doctors.

During 1976, when family planning centres were introduced, maternity leave of 90 days was approved by Decree-Law No. 112/76. In Article 68 of the Portuguese Constitution the state recognizes the importance of maternity by "protecting the mother in her irreplaceable role in the upbringing of children and by guaranteeing her

professional status and her participation in the civic life of the country".

Women receive free or cheap medical assistance throughout pregnancy and during the postnatal period. Order No. 186 of 1973 prohibits women from carrying out certain tasks or puts a limit on these tasks whenever they affect their childbearing ability. The social security system also provides a birth and feeding allowance during the first eight months of a child's life. In addition, a family allowance in cash is given to the family of each child.

The Ministry of Social Affairs recently promulgated a social statute of parents to ensure that the family is considered a fundamental social institution in society. This statute establishes principles that the Ministry intends to develop into specific laws later. The principles include:

- the granting of temporary leave to parents, without suspension of social benefits, when it is considered necessary for them to accomplish their duties as parents;
- the development of more part-time jobs and flexible timetables to permit a greater balance between professional and parental responsibilities; and
- the provision of a subsidy to help parents with financial obligations when they are temporarily unemployed.

Under the new family law, which was introduced when the Civil Code was revised in 1977, the wife acquired equal status with her husband. The concept of "head of the family" disappeared. Shortly thereafter, in 1979, Decree-Law No 392/79 of 20 September 1979 guaranteed men and women equality in employment and work. One difficulty with the implementation of this Law is the lack of public kindergartens for young children. Since women cannot always find a place to keep their children, while they are working, it is sometimes necessary for them to remain at home instead. The expense of private child care is also sometimes too high to justify the woman going to work.

In 1978 there were 2116 public and private infant care centres in Portugal, including nurseries and kindergartens, with a total attendance of about 92 360 children. The vast majority of these centres were private.

Recommendations

1. The law regarding the insertion of IUDs should be clarified to permit midwives and nurses to insert them. These personnel should receive the same protection as doctors receive under the medical practice act.

2. Sterilization should be legalized and offered as a form of birth control. Some doctors already interpret the Portuguese Constitution, which says family planning should be offered to everyone, to mean that sterilization is permissible since it is a form of family planning. They argue that, since the Constitution is the highest law of the land, legislation that prohibits sterilization is unconstitutional.

3. Abortion should be legalized during the first trimester for medical, eugenic, social and legal reasons. It should be performed in an approved place, either in a hospital or in a health centre.

4. Teenagers under 18 years of age should be given free access to contraceptive services. The law should permit anyone, regardless of age or marital status, to receive information and counselling about the contraceptive of his or her choice.

5. Legislation should be introduced to provide more public kindergartens. Companies employing more than a certain number of people, say 50–100, should be required to provide a nursery on the premises.

6. The law should require a woman to undergo an initial examination by a health professional before the Pill can be prescribed. Prescriptions for a set period of time should then be refilled without the necessity of another examination. At the end of the set period, a follow-up examination should be required before a new prescription is made out.

SPAIN

In former years, the official government policy in the area of family planning was pronatalist. All types of contraceptive, abortions and voluntary sterilization were banned. Women were encouraged to remain in the home and not to work after marriage. Section 416 of the Penal Code prohibited the advertising, manufacture and distribution of any type of contraceptive. Nevertheless, even during that period, many people were using contraceptives. Some obtained them illegally, while others received them through medical prescriptions. For example, the Pill was prescribed "to regulate ovulation". Although many people could obtain contraceptives, the knowledge of how to use them properly was limited to a certain cultural niveau.

The first legislative activities of the Ministry of Public Health and Social Security to encourage family planning programmes took place in 1977, when a seminar was held in Minorca attended by

gynaecologists, demographers, lawyers and public health personnel. The Minorca meeting, considered to be the place where family planning programmes in Spain were created, made several recommendations. The first was to abolish Section 416 of the Penal Code and to legalize contraceptive usage. The meeting acknowledged that there was a serious lag between reality and the attitudes of the government and agreed to develop family planning programmes as a "means to improve the quality of life".

Shortly after the meeting, the section in the Penal Code prohibiting the use of contraceptives was amended (Law No. 45 of 7 October 1978). Although no statistics exist, the Ministry of Public Health and Social Security is certain that the use of contraceptives since 1978 has increased. Official family planning centres were established by the central government in various parts of the country by the same Law, but little public money has been allocated in the budget for these centres.

It has been left to the local municipalities, to a large extent, to develop family planning centres. Many of them do not have sufficient financial resources to prepare and staff centres adequately. Often local centres attempt to fill the gaps left by the national family planning centres. When the law specifically prohibits an activity they follow the law (for example they will not perform abortions or sterilizations) but when the law is ambiguous each centre will make its own interpretation. The law does not indicate whether IUD insertion is legal or not, so most local centres will insert them.

Frequently, it depends where an individual lives whether he or she will be able to receive family planning services. The law makes no distinction between married and unmarried women, but some centres will not assist single women.

At present, abortion is not legally performed, except to save the life of the mother. If a woman comes to a government family planning centre and asks for information about where to obtain an abortion she will be turned away without help. The government centres are not permitted to perform or provide information about abortions, and they comply with this order for fear of losing their government funding. Some independent centres will, however, help a woman arrange to travel to another country where the laws are less restrictive. People continue to be prosecuted for providing or obtaining abortions.

Most types of contraceptive are distributed through the social security system and anyone receiving them at a centre pays only 40% of their cost. Those buying them over the counter without a prescription must pay the full cost. IUDs are distinguished from other types of contraceptive and are considered medical apparatus, in the

same way as crutches for instance. They are inserted free at government family planning centres.

The law is not clear about who is permitted to insert IUDs and diaphragms. Sterilization remains illegal except in certain medical circumstances.

Recommendations

1. The law should allow people to choose freely the type of contraception they wish to use, including sterilization. Sterilization should be permitted for social as well as for medical reasons.
2. The legislature should clarify the laws on social security. The full cost of contraceptives should be covered by the social security system.
3. Abortion and sterilization should be legalized.
4. Comprehensive legislation should be developed to regulate the operation of family planning centres.
5. Agricultural workers and housewives are not covered by the social security system. The law should be extended to cover all citizens in society.
6. The law should be clarified as to who is permitted to insert IUDs and diaphragms. If nurses and midwives are permitted to perform these insertions, the medical practice act should cover them in the same way that it protects doctors.
7. Opportunities to inform the public about family planning should be made available. The law permitting the dissemination of information must be enforced. Although the distribution of information on contraception is no longer a crime, in practice it is not always possible to distribute information freely.

TUNISIA[a]

During the past century, the legislation in Tunisia on family planning has undergone a remarkable transformation. Before independence in 1956 Tunisian legislation was almost a direct reflection of French legislation on this matter, and the official policy favoured large families. Much of the legislation promulgated during this period supported this goal.

[a] Much of the information in this section comes from Ghachem, A., unpublished data, 1980.

In 1920, for political reasons appropriate in France, the French legislature promulgated legislation prohibiting any propaganda that supported contraception and introducing penal sanctions to support the restriction. During that same year, the Tunisian legislature, following the French lead, passed a similar piece of legislation. In addition, the sale of any contraceptive devices was prohibited.

In 1923 another law prohibited the importation of any articles, remedies and instruments that prevent pregnancy. A 1942 law prohibited any publicity about contraceptives or abortions.

A decree in 1944 provided a certain amount of money for each child regardless of the number of children in a family. This law did nothing to discourage either early marriage or polygamy.

After independence, Tunisian policy changed to one that favoured the regulation of births. The 1956 Code of Personal Status replaced Koranic law in areas of marriage, divorce and children's rights. The goal of those planning this social transformation was to integrate the appropriate traditional aspects of life into the new social order. Islam became the official religion, but the emphasis was on changing not on maintaining the past ways. The Code was particularly important for the status of women. It eliminated polygamy, thereby making Tunisia the first Arabic country to explicitly outlaw this practice. One reason for abolishing it was the hope that this would help reduce the birth rate. It also removed marriage and divorce from religious courts and made them civil matters. The husband could no longer obtain a divorce by unilateral repudiation. The Code fixed the legal age for marriage at 17 years for women and 20 years for men. Below those ages, special permission from the court was required. Young people were permitted to participate in choosing their spouses and the practice of very young marriages was discouraged.

This policy, as in Morocco, encountered strong opposition from those committed to maintaining the status quo. In 1956 a group of judges sponsored a petition against the Code; some even refused to enforce the law. Instead of bending to the pressure, however, the government arranged to have these judges transferred or pressurised into abiding by the Code. President Bourguiba (*16*) said during this period: "In this country, we intend to behave like civilized men. As a citizen, a wife and a mother, a woman has rights which no one is going to take away from her".

Other laws also indicated the government's commitment to family planning. Act No. 60-30 of 14 December 1960 organized the social security system and modified the law of 1944 that gave unlimited family allowances. The new Act limited the benefits to four children.

In 1961 a law abrogated all the texts that prohibited the sale, use, importation, distribution and advertising of contraceptives.

Law No. 64-46 of 3 November 1964 required a medical examination to be carried out on both partners prior to marriage. Doctors were permitted to postpone marriages where one of the partners had tuberculosis, for instance.

In 1965 the first modification of the abortion law took place. Before that time, abortions were only permitted to save the life of the mother and the consent of three doctors was required. Therapeutic abortions were granted by Law No. 65-24 of July 1965 for two reasons: social, after the birth of four children, and medical, if the health of the mother was in jeopardy. In reality it was difficult to persuade physicians to perform abortions for these reasons, and the law was amended again in 1973 (Decree-Law No. 73-2 of 26 September 1973 amending Section 214 of the Penal Code). All abortions were authorized during the first trimester. After that time, abortions were permitted if there were physical or psychological problems or problems with the fetus. There were three requirements for an abortion to be performed after the first three months: it had to be performed in a hospital or clinic; it had to be performed by a doctor; and there had to be medical indications. There is no problem with the interpretation of the law now because medical indications include both mental and physical factors. Sterilization is encouraged in hospitals and clinics, but it is defined as permissible only for medical reasons.

Birth control pills are covered by a 1961 law on pharmaceuticals, so in theory they can only be prescribed by a doctor. In practice, the Pill can be obtained without a prescription. All contraceptives are free if they are obtained in government centres.

Law No. 73-17 of 23 March 1973 created the National Office for Family Planning and Population. This Office is entitled to provide information and technical tools to the entire family planning structure, including the private sector, clinics and hospitals. Its long-term objective is to reduce population growth to 1% per annum by the year 2000. Decree No. 74-62 of 31 January 1974 introduced the higher Council on Population and the Regional Population Councils. The members of the Higher Council are all ministers of the national organizations of family planning, and they develop the general policy for family planning activities. They also established the general outlines for legislation in this area. The Regional Councils work on a regional level.

In 1968 women were given equal pay for equal work. The Labour Code requires factories and workplaces with more than 50 women employees to make a room available for breastfeeding. Everyone is entitled to an old age pension.

Under the law, everyone is eligible for family planning services,

but the coverage is still limited. According to Dr Mohamed Bouzidi there are theoretically family planning clinics throughout the country, but in January 1980 only 25% of the women in the middle of the country had access to them. Many women do not know about the clinics; others are geographically remote from them.

Today, Tunisia is the Arab country where the greatest advances in legislation in the field of family planning have been made. It is important to continue implementing this legislation and to make access to family planning available throughout the country.

Recommendations

1. There should be specific legislation on sterilization. At present, doctors interpret the law to permit sterilization in most circumstances. The law should be made more explicit so that medical interpretation will not be necessary.
2. Legislation should be drafted to permit nurses and midwives to insert IUDs and to give them the same protection under the medical practice act that is given to doctors. At present, midwives and nurses are performing these tasks without legal protection.
3. Legislation exists concerning the proper standards for medical research, and equivalent legislation regarding the proper standards to be used in family planning research should be drawn up.

TURKEY[a]

Since the declaration of the Turkish Republic in 1923, there have been two population policies: a pronatalist policy up to 1965 and an antinatalist policy thereafter.

By 1922, Mustafa Kemal Atatürk was defending a policy of population growth. Because of a high infant mortality rate and the great number of deaths during the independence struggle and the First World War, an increased population was deemed desirable. At that time the population policy consisted in trying to reduce the infant mortality rate, curbing epidemics and repatriating Turks from outside the borders. In the 1931 Third Annual Party Congress, the platform specified that measures to increase the population would be pursued very carefully.

[a] Much of the information this section comes from Levine & Üner (*13*).

During this period, several laws were passed that had implications for population growth, although it is unclear whether these laws had any actual effect. Most of the laws were introduced not to influence population policy but to acknowledge existing practices and social conditions. In 1926 the Turkish Civil Code reduced the age of marriage for women to 17 years and for men to 18 years. In 1938 an amendment further reduced the age to 17 years for men and 15 years for women. Although this can be viewed as a pronatalist policy, the actual purpose of this law was to acknowledge existing rural customs.

Several laws were intended to help increase fertility. The Law on public hygiene passed in 1930 required the then Ministry of Health to encourage births, to grant monetary awards or medals to women who had six or more children, and to prohibit the import or sale of contraceptives. Other laws granted an amnesty to parents, allowing them to register officially children born out of wedlock.

The government also followed a strong anti-abortion policy. In 1926 the new Penal Code considered abortion a crime. A 1936 amendment increased the penalty and penalized any action that attempted to avoid pregnancy. In 1953 the penalties were again increased.

Several laws also granted tax exemptions and allocated certain resources to families with a number of children. Families were given priority in land distribution (1938) and income tax reductions (1949), civil servants received child support payments (1944) and women who had given birth were entitled to maternity leave (1971). There were also laws that gave legal and financial benefits to immigrants.

Despite the passing of all this legislation and the official government policy, it is doubtful whether these measures had the effect of increasing the birth rate. According to a Turkish study (*13*) the growth of the crude birth rate up to 1935 and the decrease thereafter were much too smooth to be responses to legal measures and did not seem to fit any legal or administrative decision.

The first attempt to modify the population growth policy did not occur until 1958, when an ad hoc committee was set up by the then Ministry of Health to investigate the substantial number of illegal abortions and to discuss measures that could be taken to counteract this problem. Its report (*17*) indicated that some of these abortions were being performed by doctors for their own profit and were conducted in places that were inadequately equipped for this type of operation. This was resulting in many serious medical complications as well as the occasional death. Legal modifications were recommended to make abortion legal in certain circumstances of medical necessity. The committee also suggested that contraception be legalized to permit women to avoid unwanted pregnancies. The report

called for the law to be changed so that women could benefit from harmless contraceptive methods and devices as they did in other civilized countries.

In 1960 the State Planning Organization (SPO) was founded and an agreement was reached between the SPO and the then Ministry of Health on the need to change the traditional population policy. The first five-year plan discussed the problems of rapid population growth and urged the necessity of controlling the population. The plan supported the repeal of the anticontraceptive laws, the creation of a family planning programme, the training of health personnel in family planning, and the provision of family planning education to the public.

A law on family planning was prepared and enacted in 1965 (Law No. 567 of 1 January). According to this law, the purpose of family planning was to allow individuals to have as many children as they wanted and to permit the use of contraception to this end. The Ministry of Health and Social Assistance was given the responsibility of follow-up. Abortion and sterilization were allowed only for strict medical purposes. At the same time the Directorate-General of Population Planning was set up in the Ministry of Health and Social Assistance, and in 1967 a regulation was passed listing the medical necessities required for abortion and the conditions for sterilization (Decision No. 6/8305 of 12 June). Otherwise, there has been no change in the 1965 policy.

The second five-year plan extended the scope of family planning services and set itself the goal of 2 million women practising some type of contraception by 1972. The third five-year plan attempted to integrate family planning with mother and child care. Neither the second nor the third plan reached its target.

In 1965, after the passing of the law on family planning, the Directorate-General of Population Planning decreed that the main goal of the family planning programme was to have IUDs inserted and that this work should be done only by medical doctors. In 1968 the distribution of oral contraceptives was also permitted, although emphasis was and still is on the IUD. Medical doctors are still the only persons permitted to insert the IUD, although some experimentation is at present being carried out whereby midwives are inserting this type of contraceptive. These experiments are proving successful and the Ministry intends to introduce a bill to permit midwives to engage in this practice legally.

Family planning policy has remained within the exclusive jurisdiction of the Ministry of Health and Social Assistance. Informal contacts have been attempted with other ministries – for example the Ministry of Education has engaged in the teaching of family planning

in some villages – but this cooperation has not been institutionalized.

The number of family planning clinics has grown gradually until there are now approximately 600, although some are inactive. One explanation for this is that a number of doctors have moved to the big cities, leaving rural areas underserved. Since doctors have been given the main responsibility for inserting IUDs, the expansion of the programme has not been possible. Official figures indicate that while IUD insertion increased between 1965 and 1969, it has decreased by 5% over the last 13 years. The number of contraceptive pills dispensed has been increasing and the Pill accounts for approximately 24% of all official contraceptives distributed. The unofficial use of contraceptives is greater than the official figures show. This may be accounted for in part by distribution by the private sector. There are no data on the extent of private distribution of oral contraceptives, but it appears to be in excess of the number distributed by the Ministry of Health and Social Assistance. Approximately 40% of married women of reproductive age are currently using contraceptives, including traditional methods. Modern methods are used by approximately 18% of women in the fertile age group.

More women are using contraceptives in Turkey today, but about 60% of the female population of reproductive age is still not using any type of prevention. Illegal abortion is still widespread.

The Ministry has drawn up several proposals for changes in the law, and it remains to be seen whether they will be accepted. They include:

- a liberalized abortion law, introducing social and economic indications for the first 12 weeks of pregnancy;
- a liberalized voluntary sterilization law with acceptance by the spouse as a requisite; and
- provision for nurse–midwives to be permitted to insert IUDs.

Recommendations

1. It is very important that the recent legislative proposals made by the Ministry of Health and Social Assistance be adopted. In addition, it would be helpful if women received greater social security benefits. The Labour Act should be extended to include agricultural workers; this would greatly increase the number of women workers covered. Women who remain at home should also be protected through an improved social security system.

2. The enforcement of existing laws should be encouraged. For example, if families are not prosecuted for violating the law on early marriage in girls, this practice will continue.

3. The law regarding maternity benefits should be unified so that all women receive equal coverage. As the law stands at present, some women are at a disadvantage because they work in a sector that provides less coverage than other sectors.

4. The law setting a minimum age of marriage should be strictly enforced. Although sanctions exist, the fact that prosecutions rarely occur encourages people to violate the law.

5. The law should be extended to protect children who are exploited or who have been forced into unwanted early marriages. These children should be offered shelter and food. At present, Turkey has a few child care and training homes but these homes take in all kinds of children ranging from the mentally ill to orphans. Non-delinquent adolescents and healthy adolescents should be separated from the rest so that further exploitation does not occur.

6. Child care facilities should be extended to all workers. Employers should be counselled not to keep the number of women workers deliberately below the minimum level required before nurseries must be provided.

PART III

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

For most of the countries in this survey, the past two decades have seen the birth of government-sponsored family planning programmes and the introduction of legislation to regulate and implement them. During this period, many of these countries have moved from a pronatalist policy to a fertility regulation policy that emphasizes the benefits to the health of mother and child.

This change is compatible with their national development goals. Governments have come to believe that uncontrolled population growth places an undesired limit on their potential for socioeconomic development. They have also started to acknowledge the right of people to control the number and spacing of their children, although this human rights issue appears to be a secondary goal within the overall planning policy.

Now that programmes have been established, the next few years will determine the direction they follow. No family planning programme has a chance of success unless it is integrated into the health and delivery care system as a whole, into actions to abolish discrimination and to raise the economic and social status of women, and into education. Similarly, for legislation in this field to be effective, it must be accompanied by attitudinal and societal transformations. Without these changes, implementation of new or existing legislation is not feasible.

At present, there is no overall thinking in the area of family planning legislation. Every law on a specific issue is passed on its own merits, usually without any long-term analysis of its impact on family planning as a whole. Rather than being reflective, legislators tend to be pragmatic, responding to an issue as an immediate need arises. It is not common for them to evaluate the appropriateness of a piece of proposed legislation within a broader framework. Certain laws may, therefore, be inconsistent with the overall policy goals. For example, giving a family allowance to a family with four children may be contrary to the expressed government policy of encouraging people

not to have more than two children.

Likewise, some laws are passed without sufficient discussion of their implications or consequences. What impact does raising the age of marriage from 15 to 18 years have on fertility? Are there any negative aspects of such a change?

Often, even when there are laws on the statute book, they are not implemented because the government has only enacted them in response to international pressure or to please an international organization. At other times the government may wish to implement a law, but may not have the means to do so. For example, a new law may legalize the use of the Pill, but if a large proportion of the population does not have access to a pharmacy it is irrelevant whether they have permission to use this type of contraceptive or not.

Law reform depends on a variety of factors: public support for the reform, the types of institution developed to enforce the policy, the type and amount of information and publicity surrounding the reform, and the way the judiciary interprets the law.

In any discussion about legal reform, it is important to be conscious of the basic differences in the legal systems of the countries surveyed. No single solution to a problem is necessarily appropriate. Constitutional, political, philosophical and practical considersations will influence a nation's response. It is not appropriate, therefore, to expect a country to wholeheartedly endorse or adopt the legislation introduced in another country. Some of the ideas and policies of one country may nevertheless be useful to another nation with similar characteristics, especially if they are adjusted to local circumstances.

RECOMMENDATIONS

Legislation with an indirect effect on family planning

1. *Age of marriage.* Although every country has a law specifying the minimum age of marriage, the enforcement of this law should be subject to much stricter scrutiny. Legislation should also be drafted that would permit marriage only with the mutual consent of the two people involved.

2. *Birth registration.* Legislation should be drafted requiring births to be officially registered. At present, many people have no means of proving their date of birth. In order to enforce both child labour laws and minimum age of marriage laws, official proof of date of birth is essential.

3. *Divorce.* Divorce should be equally obtainable by men and women. Legislation that discriminates against women in this area should be eliminated.

4. *Polygamy.* In the light of the experience of those countries where the practice of polygamy has been legally abolished, other countries might consider introducing similar legislation.

5. *Nurseries.* Even when women wish to work outside the home, it is difficult for them to do so when there are no provisions for crèches either in the community or in the workplace. High priority should be given by governments to opening public nurseries. Legislation should be passed that would require every community to provide day care at relatively low cost or at a cost related to the income of the family. Employers with more than a certain number of both male and female employees (50–100) should also be required to provide crèches at or near the workplace.

If nurseries were conveniently located close to the workplace, more women might choose to breastfeed. This would be an added benefit for child health.

6. *Maternity leave.* Maternity protection legislation should be brought into line with the ILO Convention on Maternity Protection. Women should be guaranteed a minimum of 12 weeks' paid leave without loss of any benefits.

Women working in different sectors should all receive the same leave time. There should be no discrimination based on the type of employment a women has.

Legislation should protect a woman from being dismissed from her job during pregnancy or for a fixed period thereafter without just cause. Employers should not be legally permitted to discriminate in their hiring practices against pregnant women or women who have recently given birth.

Some countries now permit women to take unpaid leave for a specified period after childbirth while being guaranteed the right to return to work. Other countries might want to adopt similar legislation. It is important, however, that countries with this type of legislation actually enforce it so that the right to return to work is real.

7. *Social security and other benefits.* Legislation should be introduced to extend social security to agricultural workers, domestic workers and housewives. Women in the home should be given adequate protection against illness or old age, either by being paid wages for housework or by being made eligible for social security protection.

Many of the countries surveyed have different social security schemes, with varying amounts of benefits, for different groups of

workers. These schemes should be coordinated so that no single group of workers is arbitrarily discriminated against merely because of the type of work they do.

Because of the inadequacies of social security systems, many people are economically dependent on their children as security for their old age. This results in the exploitation of child labour and also has serious implications for national fertility patterns.

8. *Child labour.* Protective labour legislation should be enacted in countries where it does not exist at present. In those countries where it exists but is not enforced, sanctions should be strictly imposed on violators. It is likely that child labour will be found less useful economically if effective social security schemes are developed.

9. *Family allowances.* These should be limited in the future to the number of children a country wishes a family to have. Laws that grant money to large families serve as a disincentive to people to limit the number of children they have. To avoid penalizing existing large families the law could be introduced prospectively, only those children born after the enactment of the law being affected.

Legislation could also be introduced to offer incentives to those couples who limit their families to the number of children the government has proposed as the optimal number. Families could be given financial rewards or prior access to other government benefits, such as public housing.

10. *Other disincentives.* Laws that bestow land and other benefits on a family, based on the number of sons it has, should be redrafted to remove the sexual bias. Otherwise, families will be encouraged to continue having children in the hope of increasing the number of male babies.

Legislation with a direct effect on family planning

11. *Family planning services.* The powers, duties and responsibilities of the family planning services should be specified in legislation.

12. *Contraceptives.* In order to implement fully a family planning policy, information about contraceptives should be made widely available. Legislation that restricts the advertising or display of contraceptives should therefore be abolished. For example, some countries permit drugs to be advertised only in medical journals. Since the Pill is often classified as a medicament, advertisements for the different brands may be restricted. This requirement deprives the public of the opportunity to obtain comparative information about the effectiveness of different types of oral contraceptive. Likewise, laws that do not permit the public display of contraceptives limit the individual's freedom of choice.

13. *Prescription requirement.* There should be more discussion about the necessity of requiring a doctor's prescription for oral contraceptives. At present there is no legislation in the countries surveyed that permits midwives and nurses to prescribe the Pill. Although the rationale for requiring a doctor's prescription is legitimate – to avoid the indiscriminate use of dangerous drugs – it is possible that alternative means could be found that would accomplish the same purpose and still broaden the opportunities for the public to acquire the Pill legally.

IPPF (*1*) suggests several alternatives to the doctor's prescription, as follows:

- to derestrict certain oral contraceptives so that no prescription is required; this change would legally recognize that the benefits of making the Pill accessible outweigh the possible risks;
- to permit oral contraceptives to be prescribed by paramedical workers such as midwives and nurses, or by government-authorized personnel such as field staff workers; or
- to require an initial doctor's prescription or later screening by a doctor for oral contraceptives, but to permit the consumer to be resupplied on a continuing basis by a dispenser who is not a doctor.

14. *Sale of contraceptives.* Legislation should be drafted that would permit all contraceptives, except the oral ones if they are considered medications, to be sold outside pharmacies.

15. *Insertion of IUDs and contraceptive advice.* Legislation should give appropriately trained midwives and nurses permission to insert IUDs and to advise on and dispense contraceptives. This would greatly increase the number of personnel qualified to offer preventive services and ensure wider coverage. In some of the countries surveyed this could be accomplished through existing legislation that permits doctors to delegate responsibility to other health personnel. In countries where this is not permissible at present, the law should be changed to allow this type of delegation by doctors.

It is also important that the medical practice act should be extended to ensure that nurses, midwives and other medical personnel who are performing these services are legally protected. In many instances this would merely give legal authorization to people to perform services they are already, in fact, providing.

16. *Sterilization.* In some of the countries surveyed there is no law expressly prohibiting voluntary sterilization. In those instances the procedure is probably already legal although the practice is limited. It would be useful for the governments to publicize this fact, so that doctors who wish to do so would not abstain from performing this operation for fear they may be violating the law.

In other countries sterilization is expressly forbidden, and those performing the operation are subject to criminal penalties. Although prosecutions are rare, the fact that the prohibition exists may deter some doctors from sterilizing people who have requested the operation. It is recommended, therefore, that voluntary sterilization be legalized and that guidelines be established to ensure that the operation is performed on consenting adults or, if it is performed on persons held to be incompetents or on minors, that their rights are adequately protected.

17. *Abortion.* Abortion remains one of the most controversial issues in every country in the survey. It is evident, however, that in countries where abortions are totally illegal or performed only under certain limited circumstances a large number of women obtain them illegally instead. Legal restrictions appear not to deter women who are determined to obtain this operation: they leave the country, pay a doctor or other person handsomely, or resort to folk remedies. The law simply makes abortions more difficult to obtain and thereby, in many cases, more hazardous for the health of the woman.

In most instances, other types of contraception are a more desirable means of fertility control, although at present there is no ideal method. Most contraceptives have side effects that make them unsuitable for some people. Furthermore, they are effective only if they are used regularly and properly. At least in the short run, countries should realize that abortion will continue to be a last resort when contraception fails. Abortion and contraception cannot, therefore, be regarded as independent of each other.

As family planning programmes develop and information about the proper use of contraceptives reaches a wider public, it is likely that the use of abortion will diminish. It is unlikely, however, that the practice will disappear entirely. Given this reality, it is recommended that countries begin to develop legislation that will provide women with access to safe, low-cost abortions.

Family planning for adolescents

18. *Availability of services.* In many countries, family planning services that are available to adults are not offered to minors at all or only with the consent of their parents, spouse or guardian. In order to offer this high-risk group access to services and still ensure that minors are well informed and protected, several alternatives to parental consent have been proposed by IPPF (*1*). Any one of these alternatives could be developed into some form of legislation.

1. *Mature minor doctrine.* Minors who are sufficiently mature to understand the nature and consequences of the medical treatment proposed for their benefit should be able to give legally effective consent.
2. *Emancipated or partially emancipated minor doctrine.* Where minors are married, live apart from their parents, are self-supporting or already make major decisions affecting various facets of their lives, they should be able to give legally effective consent to medical treatment.
3. *Surrogate parents.* Another adult – aunt, older sister or teacher – could be used as the source of any required consent in cases where the minors choose not to involve their parents.
4. *Ombudsman or child advocate.* These could be appointed to protect the interests of the minor in "emergency" cases or where the minor is "neglected or abused" or in moral danger and hence is at odds with the parents, or where it can be shown that the minor will be harmed if the parents were informed. This approach would depend on the existence of the proper judicial machinery to assess the status of the youth and make the appropriate appointment.
5. *Special legislation.* Special legislation could be formulated – especially relating but not restricted to contraception, pregnancy, abortion, sexually transmitted diseases and drug abuse – which expressly permits teenagers to consent to medical treatment without parental involvement.
6. *Parental notification.* It has been suggested that a notification requirement would be less of a barrier than one for parental consent. However, it seems clear that many youths who seek treatment in sexual matters do not want their parents to know about it and will not seek the treatment unless they are assured of confidentiality vis-à-vis their parents. The notification requirement must then be seen as undesirable, yet it may provide a reasonable middle ground as long as the parents cannot block the wishes of the minor.
7. *Privacy between doctor and patient.* One of the basic tenets of medical practice protects the confidentiality of the doctor/patient relationship. Though at times this may conflict with the strictest reading of the consent law, it may be invoked to protect the interests of the youthful patient. The doctor's duty is to the patient, and where he perceives that the interests – and these may be health-related – are not served by consulting the parents, he may proceed in good faith to treat a patient.

19. *Information availability and sex education.* One aspect of a good family planning service is keeping the public, including teenagers, informed about the family planning programme. Since it is clear that the age of sexual debut today is lower than in the past, it is important that teenagers receive information about fertility control and family planning. This information may be given as part of the school curriculum or distributed through the mass media. If it is included in school courses, it does not have to be considered sex education. Rather, it can be considered as part of health education and can include lessons on sex education as well as on the

social/economic/psychological aspects of family life. Even where the law permits this type of course, it is usually up to the local authorities whether it is integrated into the curriculum.

It is recommended that any legislation that prohibits sex education be removed from the statute book.

Conferences

20. *Policy-makers.* For these recommendations to be successfully implemented, it is necessary for there to be corps of lawyers and policy-makers trained in the various aspects of family planning law. It is recommended, therefore, that a regional seminar take place to train lawyers from various countries how to develop and implement legislation and other policies in the family planning area.

21. *Health workers.* Doctors, nurses, midwives and other health personnel working in the family planning field need to be familiarized with the legislation that governs their profession. It is recommended, therefore, that an interdisciplinary meeting be held on a regional level to discuss the role of law in family planning.

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Annex 1

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Annex 2

SUMMARY OF LAWS AFFECTING FAMILY PLANNING

Induced abortion

Greece Abortions must be performed by a physician. They are permitted to avoid an otherwise unavoidable threat to life or serious and permanent damage to the health of the pregnant woman and the need must be certified by a second physician; in the case of rape, incest or seduction of a girl under 16 years; up to the 20th week for fetal abnormality; and up to the 12th week in the case of a threat to the woman's mental health, with a certificate from a psychiatrist in a public health centre. Penal Code, Articles 304 and 305.

Italy *1st trimester:* an abortion can be performed at the request of the woman, in an authorized centre. If the physician finds termination urgent, the woman may receive an immediate abortion. Otherwise, she must reflect for seven days before she can receive an abortion. *After 1st trimester:* abortion is permitted where pregnancy or childbirth is a serious threat to the woman's health or there is fetal abnormality, and with the consent of a parent, a guardian or a magistrate if the girl is under 18. Law on social protection of motherhood and voluntary termination of pregnancy.

Morocco Abortion is permitted only to save the life or health of the mother and must be performed by a physician. Spousal consent is necessary and if it is unavailable, the chief medical officer must be informed. Penal Code, Articles 449–458.

Portugal Abortion is illegal, which has been interpreted to mean illegal even to save the life of the mother. Penal Code, Section 358.

Spain Abortion is illegal, which has been interpreted to mean illegal even to save the life of the mother. Penal Code, Sections 413–415.

Tunisia *1st trimester:* abortion is permitted at the request of the woman, if performed by a physician in an authorized centre. *After 1st trimester:* abortion is permitted if the life, health or mental balance of the woman is endangered or if the fetus has a disease or defect. Decree–Law of 26 September 1973.

Turkey Abortion is allowed if the woman's life is endangered, there are fetal abnormalities, or in the case of rape or incest. All cases, unless it is an emergency, require the approval of a committee. If the girl is a minor, her parents' or guardian's consent is required. All abortions must be performed in authorized centres. Law No. 765 as amended by Law No. 557 of 1965 relating to Sections 136 and 137 of the Penal Code.

Voluntary sterilization

Greece It is a crime to intentionally inflict corporal injury but the injury is not unlawful if the injured person consented and the injury does not violate "good morals". Penal Code, Section 308, Para. 1.

Italy Voluntary sterilization is decriminalized. Law No. 194, Section 22, of May 1978.

Morocco The legal status is unclear. Some sterilizations are performed in authorized hospitals.

Portugal Sterilization is illegal. It is considered aggravated corporal injury (rendering any organ of the body useless). The statute of physicians prohibits the use of methods that lead to sterility unless the patient's life is endangered. Penal Code.

Spain Sterilization is illegal. Penal Code.

Tunisia There is no official legislation. The President has called it an acceptable means of family planning if there are a sufficient number of children.

Turkey Sterilization is prohibited except for therapeutic reasons. Penal Code, Section 471, Para. 1.

Greece There is a new government family planning programme. All pharmaceutical products must be approved by the State Laboratory for Control of Pharmaceutical Products. No oral contraceptives are manufactured or tested locally. A prescription is required for oral contraceptives but this requirement is rarely enforced. IUDs must be inserted by a physician.

Italy The advertising and promotion of contraceptives is permitted. Contraceptives are sold in shops, by mail and in vending machines. Oral contraceptives must be prescribed by a doctor. IUDs must be inserted by a doctor.

Morocco The advertising and promotion of contraceptives is permitted. Contraceptives can be purchased at pharmacies. Nurse–midwives are being used to insert IUDs. A doctor is required to write the first prescription for the Pill and a resupply is then freely available. Pills are dispensed by doctors, nurse–midwives or pharmacies.

Portugal The importing and manufacturing of contraceptives is permitted. UNFPA supports six family planning projects. Contraceptives are distributed free at family planning centres through a WHO grant. A prescription is required for oral contraceptives but this requirement is not strictly enforced. Some nurse–midwives are being trained to insert IUDs under doctors' supervision.

Spain The promotion and distribution of contraceptives is permitted. The cost of the Pill is covered by social security if it is obtained at a family planning centre, where the woman pays 40% of the cost. A prescription is required for oral contraceptives, but this requirement is not strictly enforced.

Tunisia Contraceptives may be advertised to physicians and pharmacies, and to the general public if a "visa" is obtained from the public health authorities. A prescription is required for oral contraceptives but this requirement is not strictly enforced. Nurse–midwives can insert IUDs. Doctors can sell contraceptives where there is no pharmacy within 25 km.

Turkey The Government has had family planning programmes since 1965. Advertisements are unrestricted and displays are permitted in pharmacies. Every sort of contraceptive must be tested in the country before it is distributed. Contraceptives are available in pharmacies and shops. A prescription is required for oral contraceptives but this requirement is not strictly enforced.

Legal age of marriage

	Women	Men
Greece	14	18
Italy	18[a] 16[b]	18[a] 16[b]
Morocco	15	18
Portugal	18[a] 16[b]	18[a] 16[b]
Spain	18[c]	18[c]
Tunisia	20[a] 17[b]	20
Turkey	15[d]	17[d]

[a] Without parental consent.

[b] With parental consent.

[c] The age of majority. A judge may lower the age to 14 for both sexes (Civil Code, Paragraph 48).

[d] A judge may lower the age to 14 for women and 15 for men.

Time off for breastfeeding

Greece State employees: for the first two years, two hours off in the morning or afternoon daily; for a child of 2–4 years, one hour off daily.

Italy Two one-hour breaks a day during the first year. Alternatively, the woman can leave work early, unless the child is in a crèche set up by the employer in the workplace.

Morocco Two 30-minute periods a day for one year.

Portugal Two 30-minute periods a day for nine months.

Spain One hour off a day for nine months.

Tunisia Two 30-minute periods a day for one year.

Turkey One hour off a day for six months.

Maternity leave

Greece Private employees receive 42 days off before the birth and 42 days off after. Half the salary is paid by the employer and half by social security. Public employees receive two months off before the birth and two months off after.

Italy Two months off before the birth and three months off after. The law also gives a woman the option of taking six months off during the first year after her child's birth. Act No. 1204 of 1971, respecting the protection of working mothers.

Morocco Twelve weeks off with pay, half of which must be taken after the confinement. Decree of 2 July 1947 to regulate employment and Dahir of 24 April 1973 to promulgate Act No. 1-72-219.

Portugal Ninety days' paid leave with full wages for civil servants or the equivalent from the social security system for others. Decree-Law No. 112/76 of 1976.

Spain Twelve weeks off, six weeks before the birth and six weeks after. Act No. 16 of 8 April 1976.

Tunisia One month's paid leave, which may be extended for 15 days with a medical certificate. Act No. 66-27 to promulgate the Labour Code of 30 April 1966.

Turkey Time off depends on which sector the woman works in: usually six weeks off before birth and six weeks off after. Civil servants are permitted three weeks off before birth and six weeks off after. Labour Act No. 1475 of 25 August 1971.

Annex 3

POPULATION FACTS

Source: Population facts at hand. New York, United Nations Fund for Population Activities.

	Year	Country						
		Greece	Italy	Morocco	Portugal	Spain	Tunisia	Turkey
Population[a] (in thousands)	1960	8327	50223	11640	8826	30303	4221	27509
	1980	9329	56959	20296	9856	37378	6363	45346
	2000	10395	61016	36149	11466	43362	9563	69413
Women aged 15-49 years (percentage of 1960 figure)	1980	101.9	108.3	188.7	111.3	115.4	159.5	177.8
	2000	107.7	109.8	372.8	129.4	135.5	277.6	299.0
Crude birth rate (per 1000)	1955-1960	19.3	18.0	51.2	24.2	21.3	49.7	44.7
	1975-1980	15.6	13.4	45.4	19.1	17.9	36.7	34.9
Annual growth rate (per 1000)	1955-1960	0.89	0.82	2.77	0.50	0.84	1.79	2.85
	1975-1980	0.62	0.40	3.19	0.90	0.98	2.52	2.48
Sex ratio (males per 100 females)	1960	95.3	96.0	100.0	91.8	94.3	101.9	105.0
	1980	96.3	96.0	100.0	90.5	95.8	102.5	103.4
Urban population (percentage of total population)	1960	42.9	59.4	29.3	22.5	56.6	36.0	29.7
	1980	61.9	69.3	40.5	30.6	74.3	51.7	47.4
	2000	74.5	78.1	54.9	44.4	83.4	65.8	62.7

[a] Mid-year

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